IMPROVING HEALTHY BEHAVIORS PROGRAM IN INDIA

Contract #AID-GHS-I-00-07-00008
Task Order #AID-386-TO-11-00001 IHBP
USAID India COTR: Moni Sagar
Family Health International (FHI 360)
Annual Work Plan, Year 2
October 2011-September 2012

Improving Healthy Behaviors Program (IHBP)

ANNUAL WORK PLAN
YEAR 2

OCTOBER 1, 2011–SEPTEMBER 30, 2012

Family Health International (FHI 360)
1825 Connecticut Avenue NW
Washington, D.C., 20009
Phone: +1 (202)-884-8000
Fax: +1 (202)-884-8400
www.fhi360.org

Table of Contents

Acronyms

ACSM	Advocacy, Communication, and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
AMP	Award Monitoring Plan
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWP	Annual Work Plan
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BHEIO	Block Health Education and Information Officer
BMGF	The Bill and Melinda Gates Foundation
BMP	Branding and Marking Plan
BSS	Behavioral Surveillance Survey
CHC	Community Health Center
CII	Confederation of Indian Industry
CO	Contracts Officer
COTR	Contracting Officer's Technical Representative
CRS	Community Recognition Scheme
CSW	Commercial Sex Worker
CTA	Chief Technical Advisor
DAPCU	District AIDS Prevention and Control Unit
DFID	Department for International Development
DHFW	Department of Health and Family Welfare
DLHS	District Level Household and Facility Survey
FICCI	Federation of Indian Chambers of Commerce and Industry
FP/RH	Family Planning/Reproductive Health
GOI	Government of India
GOUP	Government of Uttar Pradesh
HIV	Human Immunodeficiency Virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HR	Human Resource
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
ICTC	Integrated Counseling and Testing Center
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IFA	Iron Folic Acid
IFPS	Innovations in Family Planning Services
IHBP	Improving Healthy Behaviors Program in India
IIMC	Indian Institute of Mass Communication
IPC	Interpersonal Communication
IR	Intermediate Result

IRB	Institutional Review Board
IS	Institution Strengthening
ITAP	Innovations in Technical Assistance Project
JMM	Joint Monitoring Mission
JNU	Jawaharlal Nehru University
JSY	*Janani Suraksha Yojana*
KAP	Knowledge, Attitudes, and Practices
KM	Knowledge Management
M&E	Monitoring and Evaluation
Mamta – HIMC	Mamta Health Institute for Mother and Child
MCH	Maternal and Child Health
MCH STAR	Maternal and Child Health Sustainable Technical Assistance and Research
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant
MOHFW	Ministry of Health and Family Welfare
MOWCD	Ministry of Women and Child Development
MSM	Men Who Have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NHCS	National Health Communication Strategy
NIHFW	National Institute of Health and Family Welfare
NIPCCD	National Institute of Public Cooperation and Child Development
NRHM	National Rural Health Mission
ONA	Organization Needs Assessment
PAG	Project Advisory Group
PCI	Project Concern International
PHC	Primary Health Center
PHFI	Public Health Foundation of India
PIP	Program Implementation Plan
PLHIV	People Living with HIV
PPP	Public-Private Partnership
PRI	Panchayati Raj Institution
PSI	Population Services International
RCH	Reproductive and Child Health
RFP	Request for Proposal
RGI	Office of Registrar General India
RNTCP	Revised National Tuberculosis Control Program
SACS	State AIDS Control Society
SAP	State Action Plan
SBCC	Social and Behavior Change Communication
SIFPSA	State Innovations in Family Planning Services Project Agency

SIHFW	State Institute of Health and Family Welfare
SOW	Statement of Work
SPAG	State Project Advisory Group
SPMU	State Programme Management Unit
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	United States Agency for International Development
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WHO	World Health Organization

I. Background

A. Introduction

On October 25, 2010, the United States Agency for International Development (USAID)/India awarded a Task Order to AED (now FHI 360) to implement a project called "Behavior Change Communication – Improving Healthy Behaviors Program in India" (IHBP) for a base period of 3 years with 2 option years. The overall goal and approach of IHBP is to improve adoption of positive healthy behaviors through institutional and human resource (HR) capacity building of national, state, and district-level institutions. The geographic focus at the state level is Uttar Pradesh (UP), where IHBP will cover 10 districts.

Now approaching its second year, IHBP provides technical assistance (TA) to develop sustainable national-, state-, and district-level institutional capacity to design, deliver, and evaluate strategic evidence-based behavior change communication (BCC) programs that will:

- Increase knowledge and attitudes of individuals, families, communities, and health providers about health
- Promote an environment where communities and key influencers support positive health behaviors
- Reduce barriers of vulnerable populations, e.g., women, people living with HIV (PLHIV), and tuberculosis (TB) patients, to demand and access health services

The project focuses on four program areas (called program elements in the Task Order): HIV/AIDS, family planning/reproductive health (FP/RH), TB, and maternal and child health (MCH). As per USAID guidelines, IHBP's TA focuses on strengthening institutions and HR capacity for BCC in the Ministry of Health and Family Welfare (MOHFW) and the National AIDS Control Organization (NACO) and their affiliate training institutions, like the National Institute of Health and Family Welfare (NIHFW) and the State Institute of Health and Family Welfare (SIHFW), and agencies designated as government communication counterparts, like the State Innovations in Family Planning Services Project Agency (SIFPSA) in UP. IHBP is supporting efforts to strengthen BCC capacity in the Ministry of Women and Child Development (MOWCD) and its state counterpart, which will improve information and communication activities within its Integrated Child Development Services (ICDS) program.

This narrative describes the annual work plan (AWP) for the project's second implementation year, from October 1, 2011 to September 30, 2012.

B. IHBP Intermediate Results

USAID/India's Health Results Framework aims to improve the health of target populations and to reduce morbidity and mortality in support of India's efforts to achieve the Millennium Development Goals (MDGs). USAID's Assistance Objective in India is to strengthen health systems to address the health needs of vulnerable populations. IHBP will contribute to achievement of this Assistance Objective, specifically, to Intermediate Result (IR) 3, Increased Healthy Behaviors, through four key results:

- **Result 1:** Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels
- **Result 2:** Accurate and appropriate knowledge/attitudes increased in individuals, families, communities, and providers at district, state, and national levels
- **Result 3:** Community platforms, organizations, and key individuals (influencers) support improved health behaviors
- **Result 4:** Vulnerable communities empowered to seek health services and products

C. Situation Analysis and Problem Statement

With a maternal mortality rate of 254 per 100,000 live births (Office of Registrar General India [RGI], 2004–2006) and infant and under-5 mortality rates of 57 and 74 per 1,000 live births (National Family Health Survey III [NFHS-3]), respectively, India accounts for 25 percent or more of maternal and child mortality worldwide. Similarly, with 22 percent of newborns with low birth weight, 48 percent of children under age 5 stunted, 43 percent underweight, and 20 percent wasted (NFHS-3), India contributes more than 25 percent of deaths and of the worldwide disease burden among children under 5 (World Health Organization [WHO], 2006). The situation in UP is much worse than the national average, and the problem in UP is compounded by its large and primarily rural population, widespread poverty, a high illiteracy rate among its women, the inaccessibility of its vulnerable populations, and the limited exposure of its rural women to the media.

The District Level Household and Facility Survey 3 (DLHS-3) of 2007–08 found 23.8 percent of couples in UP with unmet needs for FP, but only 9.8 percent using a modern spacing method and only 6.9 percent adopting a spacing method consistently for more than 6 months. Only 22.7 percent of current users of FP had been told about the side effects of FP methods. Among the non-user couples, only 19.8 percent reported ever receiving counseling by a service provider.

With a maternal mortality ratio of 517 per 100,000 live births (NFHS-3), UP also continues to face the burden of high maternal deaths, most of which are avoidable. Only 26 percent of women in UP received three antenatal care (ANC) visits, compared to 52 percent at the national level, and only 8.7 percent reported consuming a full dose of iron folic acid (IFA) tablets. Institutional deliveries were reported at 22 percent (DLHS-3, 2007–08) and 44 percent (Population Council, 2010), and only 14 percent of mothers received a visit from a health care worker within 48 hours of delivery. A survey conducted by the Population Council (2010) cited reasons for women not opting for institutional delivery, such as the perception that delivery is normal and hence institutional care is not needed, the decision of the mother-in-law and/or husband, and lack of preparedness. The same survey established that women contacted by accredited social health activists (ASHAs) during the last delivery were three times more likely to deliver in a health facility. Additionally, having three or more antenatal checkups was positively correlated with institutional delivery, early breastfeeding, post-natal care within 7 days of delivery, full immunization of children between 12 and 23 months, and post-partum contraception for birth spacing.

The infant mortality rate in UP, 73 per 1,000 live births, is the highest of all Indian states and much higher than the national average. More than half the deaths of children who die in the first 5 years of life occur in the first month after birth. Full immunization coverage in UP is 23.0 percent, compared to 43.5 percent overall in India. Only 7.2 percent of children under 3 years in UP (versus 23.4 percent in India) are breastfed within 1 hour of birth. An average of 51 percent of children age 0–5 months in UP are exclusively breastfed (compared to 46 percent in India). About 85 percent of children 6–35 months are anemic and 52 percent are underweight.

According to Government of India (GOI) estimates, 2.3 million Indians were living with HIV in 2007, and those most at risk are female commercial sex workers (CSWs), men who have sex with men (MSM), and injecting drug users (IDUs). Women now comprise 40 percent of PLHIV. While NACO has categorized UP as a low-prevalence state, the 30 eastern districts are particularly vulnerable and include several (Allahabad, Deoria, Etawah, Banda, and Mau) classified as high-burden districts (District Categorization for Priority Attention, NACO, 2008).

Increased vulnerability in these districts is attributed to high migration, poverty, and illiteracy, compounded by groups practicing high-risk sex. A 2009 Behavioral Surveillance Survey (BSS) found that, among the general population, HIV awareness is high across all states except UP, where it is 79 percent. Rates of condom use and perception of risk levels among migrants in UP is low. The National AIDS Control Program III (NACP III) 2009 Joint Mid-Term Implementation Review identified the following BCC challenges:

- Plans focus on resources and outputs, not outcomes.
- Campaigns lack a focus on reducing discrimination and stigma by health providers.
- The capacity for quality information, education, and communication (IEC)/BCC is weak at State AIDS Control Society (SACS) and District AIDS Prevention and Control Unit (DAPCU) levels.
- Only 2 percent to 3 percent of the IEC budget goes to monitoring and evaluation (M&E).
- Interpersonal communication (IPC) activities by health workers have rarely been evaluated.

The WHO Global TB Control Report 2010 cites India as a country with a high TB burden, high HIV burden, and high multi-drug resistant (MDR) TB burden. All forms of new TB cases are estimated at 100–299 per 100,000 persons and, of these, the estimated HIV prevalence in new TB cases could be in the range of 5 percent to 19 percent. There is a 50 percent to 60 percent lifetime risk among PLHIV of contracting TB.[1, 2] The NFHS-3 revealed that the active TB population is close to 425 per 100,000 persons. In UP, prevalence rates are estimated at 426 per 100,000 persons and prevalence is highest in households using solid fuels (coal, charcoal, wood, etc.) for cooking. Misconceptions about TB transmission are high. A 2009 Joint Monitoring Mission (JMM, 2009) on the Revised National Tuberculosis Control Program (RNTCP) identified notable disconnects between interventions envisaged at the national level and what has been happening in the field, e.g., objectives and components laid out in the National Health

[1] Pathni, A.K. et al. "HIV/TB in India: A public health challenge." *Journal of Indian Medical Association.* 2003 Mar. 101 (3):148–9.
[2] http://www.searo.who.int/en/Section10/Section2097/Section2129.htm. Accessed on April 12, 2011.

Communication Strategy (NHCS) are not reflected at the state and district levels and state and district IEC action plans are not based on an analysis of needs; program data; or existing knowledge, attitudes, and practices (KAP) survey data.

The same JMM report identified these BCC challenges:

- Stigma continues to isolate patients and impairs effective referral, treatment, and care.
- IEC focuses on materials production and information rather than more persuasive, behavior-centered approaches.
- Patients have poor awareness of their disease or treatment duration.
- Mutual distrust limits civil society engagement.
- State/district managers give IEC low priority due to lack of capacity, poor perception, and inadequate recognition.

The report's major recommendations for IEC/BCC include:

- Engage professionals and/or partners to strengthen and lead advocacy, communication, and social mobilization (ACSM) strategic planning at the national level with support across the RNTCP network, and work closely with National Rural Health Mission's (NRHM) communication stakeholders.
- Concentrate on achieving universal awareness of the right to, and availability of, free TB treatment and care.
- Enhance social mobilization and interpersonal communication.

Recent systematic reviews of health interventions have documented that home- and community-based interventions implemented at scale can reduce the burden of maternal, newborn, and child mortality, morbidity, and undernutrition in settings characterized by high disease burdens and weak health systems. However, it is important to identify the key behaviors that require these targeted interventions to achieve this high impact. Socio-cultural and structural barriers, including limited awareness, socio-cultural norms, misconceptions about health behaviors, women's limited autonomy and self-efficacy, and poor access to health care, underlie the low uptake of effective practices. At the same time, more evidence is needed on the key influencers who are most likely to inspire behavior change among end-users, as well as on the factors that influence behavior change in different socio-cultural settings.

Role of Communication

Communication strategies play a powerful role in addressing many of the social and structural barriers to healthy behaviors and in shaping demand for and adoption of healthy preventive practices. However, access to BCC in HIV/AIDS, FP/RH, TB, and MCH is far from universal, particularly among women in UP. For example, the NFHS-3 reports that as many as 40 percent of women in UP had not heard or seen a single FP message through radio, TV, newspapers, magazines, or wall paintings in the months preceding the interview and that just 20 percent of women had contact with a frontline health worker in the 3 months preceding the interview.

The reach of health messages and communication materials has been low, especially in UP. The 2010 Population Council survey revealed that only one-fourth of the government's facilities had leaflets and counseling aids available, and most of these did not address specific family health issues, such as pregnancy danger signs and immunization. Only one-fifth of frontline health workers reported that they had been provided with any materials for distribution or as counseling aids. In mid-media, mainly *Janani Suraksha Yojana*[3] (JSY), immunization schedules were painted on Primary Health Center/Community Health Center (PHC/CHC) walls, and only 20 percent of facilities had wall paintings on birth spacing, post-partum care, and exclusive breastfeeding or complementary feeding.

Further, there are several drawbacks to past and current communication initiatives.

- Few are evidence-based.
- Few use integrated communications with multiple channels or attempt to use the potential of information and communication technology (ICT) applications for communicating at scale.
- Most communication initiatives fail to ensure alignment across behavioral targets, communication channels, and messages.
- Messages are often imparted in a somewhat technical way and are rarely conveyed in the local dialect; these efforts fail to address such central issues as gender inequities, reproductive rights, and the importance of sharing responsibilities among key influencers within the family.
- Various factors, including lack of training and adherence to traditional social norms, hinder the ability of health providers to promote appropriate preventive practices.
- Relatively few initiatives have been rigorously evaluated and documented.

Barriers and Facilitating Factors

Formative research conducted by the Population Council has identified key barriers and incentives that shape the demand and adoption of targeted behaviors. These are discussed below.

1. Media analysis shows that only about 48 percent of rural women in UP aged 15–34 are exposed to any mass media, and the percentage among disadvantaged groups is even lower. For a BCC strategy in rural UP, mid-media, including community radio and IPC, need to be the prime sources of information dissemination. The exponential increase of mobile phones in rural areas could provide an excellent opportunity to use mobile technology for communication.
2. Field observations show that women and community members perceive ASHAs, Anganwadi workers (AWWs), and auxiliary nurse midwives (ANMs) to be credible sources of health information. However, the study also shows that most information provided by ASHAs centers around incentivized practices, such as promoting three ANC visits, institutional delivery, and full immunization. Furthermore, the ANMs, ASHAs, and AWWs provide information only in their individual area of activities. As a result, there is no alignment of

[3] Literally translated as "Maternity Protection Scheme," JSY is a scheme under NRHM that combines conditional cash transfers, cost subsidization, and incentives for pregnant women to undertake ANC, institutional delivery, and post-natal care in a public health facility and for community health workers called ASHAs to facilitate pregnant woman's access to MCH services.

health messages. In addition, frontline workers lack counseling skills. These findings point to the need for continued education of the frontline workers in both technical areas and BCC counseling.

3. While mothers-in-law are important influencers, research shows that the involvement of husbands is critical to the adoption of healthy behaviors. BCC campaigns focusing on the family must target husbands as well as the women in the family.

BCC Structures

The 2008 UNICEF *Report on Enhanced Capacity of Government Partners for BCC* provided a comprehensive assessment of the capacity needs of the Ministry of Health and MOHFW, the GOI, and state IEC Bureaus that must be addressed to strengthen implementation of the Reproductive and Child Health II (RCH-II) program. The assessment identified organizational issues within the national and state IEC Bureaus that result in, among other things, the absence of an evidence-based integrated BCC strategy, a low utilization of funds, a focus on mass media and print materials, and the absence of pretesting of materials. The NRHM framework emphasizes the importance of a common approach to IEC for health. However, the IEC Bureaus and the Disease Control Programs do not share a common understanding of BCC. The lack of coordination with other MOHFW health programs—a situation that is evident in UP—misses opportunities to maximize outreach and effective service delivery. The Mid-Term Review Report of RCH-II (GOI, 2008–2009) highlights the following BCC gaps:

- Limited capacity within the system for management of evidence-based BCC
- Inadequate provision of crucial services like ANC, emergency contraception, and safe abortions
- Stand-alone IEC/BCC activities with minimal linkage to service delivery
- Weak counseling at facilities

BCC in Uttar Pradesh

The BCC strategy of the Government of Uttar Pradesh (GOUP) under the NRHM identified similar gaps: weak BCC supervision at the state, district, block, and village levels; weak capacity for planning and implementing BCC programs; weak community-based BCC inputs; uncoordinated and unfocused mass media campaigns; lack of capacity to implement BCC programs at scale; and a need for orienting all health personnel in the state. A review of the 2010–2011 State Action Plan (SAP) of UP reveals that the GOUP is aware of these issues. Fourteen core trigger behaviors have been identified for change and the plan includes a sound communication strategy. It proposes an integrated approach and has identified various useful village and community platforms, such as *Godhbharai* celebrations (a ceremony placing gifts on a pregnant woman's lap), *Saas-Bahu Sammelans* (mother and daughter-in-law meetings), and Village Health and Nutrition Days (VHNDs), that could be used to stimulate the adoption of target behaviors. Unfortunately, the SAP not only stops short of underlining the importance of identifying barriers and facilitating factors that affect uptake of target behaviors, but also fails to reflect appreciation of the challenges in implementing the proposed strategy, with negligible allocation of M&E resources for the BCC campaign.

The observations from the recently concluded 4th Common Review Mission for UP have implications for IHBP, especially in using ASHAs for IPC in their mentoring and supportive supervision, in improving the effectiveness of community platforms like *Saas-Bahu Sammelans* and VHNDs, and in strengthening HR for BCC in the state TB cell.

The task ahead is clearly laid out. Be it the Joint Review Missions (JRMs) called by the GOI, GOUP's NRHM BCC Strategy for UP (2008), or USAID's BCC Baseline Survey of UP, the need for an evidence-based, multi-pronged, well-planned, and consistent BCC strategy for sustained gains in health interventions is highlighted throughout.

D. IHBP Guiding Principles

The IHBP project adheres to USAID/India's funding policy, which views its resources as providing catalytic support, sources of innovation, and models and pilots for more effective and efficient use of the substantial funds that are available from the GOI and other donors. Rather than invest in direct implementation, USAID supports quality TA, cooperation, and partnership, with selected implementation and service delivery assistance to be based on compelling need or political imperatives. Using an approach of providing mainly TA, with only strategic use of limited funding for direct implementation, the project adheres to these guiding principles.

1. Focus on Systems Strengthening

The project focuses on strengthening the existing systems responsible for all aspects of BCC programming, going far beyond BCC training. It includes strengthening organizational and management structures and systems, advocating for additional HR, improving budgeting and disbursement of funds, and reinforcing coordination within relevant government departments and nongovernmental organizations (NGOs), as well as the private commercial sector.

2. Coordination and Integration

IHBP aims to enhance BCC coordination mechanisms within relevant programs of the MOHFW, the NACO, and the MOWCD at national and state levels and among key units at the district, block, and village levels. Coordination between government and NGOs, including the various health alliances working in UP, will be enhanced. During its second year, the project will establish a Project Advisory Group (PAG) with national- and state-level members drawn from different programs under the NRHM, from the MOWCD, and from stakeholder agencies. The PAG will recommend mechanisms for improving coordination between the different vertical programs of the government and will also periodically review the progress of the IHBP and provide advice on how to improve coordination. In addition, the project will make use of existing program review platforms within the system, like the JRMs called by the GOI, to advocate for enhanced coordination between programs and across government departments and to increase accountability in this regard.

3. Evidence-Based BCC

Although India's public health system has shifted toward evidence-based and outcome-oriented programming, BCC programs have not. Key recent reviews, such as UNICEF's BCC capacity

assessment, the Population Council's recent research in UP, and UP's own BCC strategy document, all identify the need for BCC programs to focus on key behaviors and to address social and cultural barriers to change and engage influencers. The project advocates for and implements an evidence-based BCC approach at all levels, with funds for implementation of BCC activities to be provided by the government budget.

4. Advocacy

Advocacy with government decision makers at all levels is a key component, since capacity building and BCC activities under all IRs need to be "owned" by the government agencies that will provide resources for implementation. Advocacy strategies are critical to building an enabling environment for BCC.

5. Accountability and Recognition

The project is helping create simple but robust M&E systems at all levels to provide feedback to health workers on their BCC performance and to institute a system that salutes ASHAs, ANMs, AWWs, *sarpanchs*,[4] community influencers, and other health providers who are proven to be "outstanding communicators for behavior change." In its second year, the project will support a system that commends mothers and fathers, TB patients, and other community members who are practicing positive health behaviors (positive deviants), so that these behaviors become community norms.

6. Leveraging

The project has identified a number of innovative public-private partnership (PPP) and leveraging ideas that have been discussed with business sector leaders and organizations, such as the Federation of Indian Chambers of Commerce and Industry (FICCI) and the Confederation of Indian Industry (CII). The project's approach to leveraging will endeavor to forge partnerships within a "win-win" setting with commercial companies, civil society organizations, government institutions, international and national donors, and the media. During its second year, IHBP will work with the commercial sector within the parameters of two general approaches: working with corporate social responsibility programs that are interested in investing in the target districts in UP or in improving BCC capacity at the national or state level, and developing sustainable "win-win" situations wherein a company can expand the commercial availability of its relevant health products or services that are a part of its core business, in collaboration with the project and USAID.

E. Implementation Strategy

Our implementation strategy for institution strengthening is to provide TA through a mentoring, learning-by-doing approach through selected nodal organizations, seconding BCC specialists to work closely with government at the national, state, and district levels, and assigning project staff at the district level to provide day-to-day TA to government partners on BCC. The project

[4] A *sarpanch* is a democratically elected head of a village-level statutory institution of local self-government called the *gram panchayat* (village government) in India. The *sarpanch* is the focal point of contact between government officers and the village community.

views *nodal institutions* as public institutions, e.g., the NIHFW, the SIHFW, and the National Institute of Public Cooperation and Child Development (NIPCCD); academic institutions, e.g., the Indian Institute of Mass Communication (IIMC), and Jawaharlal Nehru University (JNU); or private organizations, e.g., NGOs and for-profit agencies, that will provide training and technical support services to GOI and GOUP programs. During its second year, IHBP will develop the capacity of two nodal institutions, once selected and approved by government and USAID, through a mentoring approach, so that by the end of the project life, they will be able to take on the technical support role that the project has been providing.

Based on agreements to be developed with the government agencies, the project will deploy one key BCC specialist as a consultant or project resource in GOI and GOUP counterpart offices in each location. These focal persons, with approval by government, will provide day-to-day liaison between the project and department officials. In Year 2, IHBP will place four full-time consultants at both the national and state offices. One district-level BCC consultant per district, jointly selected with relevant district government personnel, with each serving 2 years, will be phased in according to the district rollout. Specific Statements of Work (SOWs), to be finalized with government counterparts, for these seconded consultants will include such tasks as:

- Developing and mentoring staff planning skills
- Increasing training skills of master trainers
- Developing evidence-based communication materials
- Strengthening organizational structures, budgeting, and monitoring

Transition mechanisms for all specialists/consultants will be put in place during discussions with government officials during project-led planning sessions and TA. Following the 2-year consultancy, the project will work to have government systems in place to support these positions, initially either as consultants transitioning to permanent hires or as permanent hires with specific job descriptions related to promoting social and behavior change communication (SBCC). Considering the importance of the district as the "key connection" between planning and implementation, the project will place three or four project-employed staff in each of the 10 priority districts, to mentor government BCC partners, e.g., the Chief Medical Officer (Family Welfare), District Health Information and Education Officers, and the District TB Officer, and to facilitate activities in institution strengthening, BCC, community mobilization, advocacy, and M&E.

Ten districts in UP to be selected by USAID and the GOUP will be the focus of activities at the state level. The strategy for district implementation will be to launch activities in six districts in the first part of Year 2 and move on to launch in the remaining four districts in the latter part of Year 2. The project has proposed district selection criteria that identifies vulnerable districts based on socio-demographic data, relevant behavioral and health service delivery indicators on the four program elements, management indicators, and the existence of USAID- or other donor-funded activities. The implementation strategy will target achievement of a core set of health behavior indicators (minimum package) in all 10 districts, which will contribute to the achievement of the MDGs in UP. Additional indicators for specific districts will be included based on the specific needs and gaps for the district, mainly on HIV/AIDS and TB.

II. Results of Implementation of the Year 1 Work Plan

AED initiated project start-up activities immediately after the signing of the Task Order on October 25, 2010. On November 29, IHBP submitted drafts of the project's AWP for Year 1 (October 25, 2010 to September 30, 2011), Award Monitoring Plan (AMP), and Branding and Marking Plan (BMP) to USAID. In early December 2010, USAID/Washington suspended AED from receiving new awards. In late December 2010, the USAID/India Contracts Officer (CO) instructed AED to "delay major actions" regarding implementation of IHBP. The major actions that were delayed included recruitment of staff and consultants; signing of office leases; procurement of major office equipment, vehicles, and furniture; and shipment of the Chief of Party's personal effects. Implementation of technical activities was likewise delayed. USAID indefinitely postponed giving comments on and granting approval for the IHBP AWP and other deliverables submitted on November 29. USAID postponed introductory meetings between IHBP and government counterparts in Delhi and Lucknow. Implementation of IHBP stalled for several months.

In early March 2011, the CO gave approval for IHBP to:

- Hire staff according to the project's approved staffing pattern
- Lease office space on condition that USAID be advised on final negotiated terms and conditions
- Based on agreement on leases, issue purchase orders for office renovation and required Internet and communication cabling
- Ship the Chief of Party's personal effects
- Execute subcontracts with the Population Council and Population Services International (PSI) approved in the proposal
- Process the subcontract with Project Concern International (PCI) for submission to USAID for approval

The CO stated that procurement of equipment over $10,000 per transaction would need USAID approval. Additionally, the CO granted approval for issuing Request for Proposals (RFPs), hiring consultants for four to six research studies and reviews as per the approved work plan, and obtaining quotes for website development and international Short-Term Technical Assistance (STTA) travel to India. It was noted that projected costs that would extend beyond June 1, 2011, needed to be kept to a minimum.

IHBP immediately reactivated staff recruitment, considering that fewer than 25 percent of the staff positions had been filled at that time. Difficulties were encountered because the acquisition of AED by FHI had not yet been announced and applicants had concerns about employment tenure. IHBP began searching for office space in Delhi and Lucknow and procuring computers for staff (previously acquired on a rental basis). As the AWP had not yet been approved, the RFPs and consultant hiring could not be done.

On March 7, 2011, USAID sent comments on the AWP, the AMP, and the BMP. On April 12, IHBP submitted revised versions of these deliverables based on the March 7 comments. USAID reviewed these April 12 submissions and sent IHBP additional comments as follows: on May 4 recommending revisions to the narrative portion of the AWP and on May 31 suggesting revisions to the tabular version of the AWP and the AMP. IHBP further revised these deliverables, along with the BMP, and formally transmitted these to USAID on June 22, 2011.

The June 22 version of the AWP describes activities that can feasibly be achieved within one quarter (July to September 2011), considering that full project start-up was delayed as a result of the AED suspension and instructions from the USAID CO to "delay major actions." Activities in this revised AWP version were reduced drastically from those identified in the first AWP dated November 29, 2010. Following the June 22 submission, the Contracting Officer's Technical Representative (COTR) gave verbal assurance that the major activities in the AWP were as good as approved. Furthermore, he gave the "go" signal for IHBP to launch technical activities. He informed the project that USAID approval of the AWP, the AMP, and the BMP would be forthcoming. On August 8, 2011, the COTR granted formal approval of the Year 1 AWP.

From the end of April to mid-June, USAID introduced IHBP to its government counterparts. Meetings were organized by USAID in Delhi with the MOHFW Joint Secretary, IEC, Mrs. Shakuntala Gamlin on April 29, and with the Joint Secretary, MOWCD, Dr. Shreeranjan on June 13. From June 6 to June 7, USAID officials and IHBP project staff travelled to Lucknow for meetings with senior UP government officials, namely, the Department of Health and Family Welfare (DHFW) NRHM Director, Mr. Mohammad Mustafa; Department of Women and Child Development Principal Secretary, Mr. Balvinder Kumar; and Uttar Pradesh State AIDS Control Society (UPSACS) Project Director, Mr. S.P. Goyal. During these introductory meetings, IHBP briefed senior officials on the project. These senior officials appointed key staff to be focal persons to closely collaborate with IHBP in planning and implementing activities. After these meetings, IHBP held discussions with these focal persons to move activities forward.

On June 30, 2011, IHBP organized a work-planning meeting with Delhi and UP technical staff and staff from PSI, the Population Council, and PCI. During this meeting, participants discussed the activities and key indicators stated in the AWP and the AMP as submitted to USAID on June 22. They identified tasks to be undertaken under each activity and staff responsible for these tasks for the quarter July to September 2011 to successfully accomplish deliverables for Year 1.

III. Annual Work Plan Year 2: October 2011 to September 2012

The Year 2 AWP focuses on achieving the indicators defined in the USAID-approved AMP. This AWP was drafted by FHI 360 headquarters and IHBP/India staff and staff from the project's subcontracting partners (PSI, the Population Council, and PCI) during a workshop held in New Delhi, August 10–12, 2011. USAID also participated in some of the workshop sessions.

The following overall framework governs Year 2 work plan activities:

IR 1	IR 2	IR 3	IR 4
Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels	**Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers at district, state, and national levels**	**Community platforms, organizations, and key individuals (influencers) support improved health behaviors**	**Vulnerable communities empowered to seek health services and products**
• Organization needs assessment • HR assessments • M&E assessments and strengthening • Institution strengthening plans • Training plans and module development and trainings from national to district level • Training master trainers at national, state, and district levels • Advocacy activities from national to district level for acceptance and government funding of institution strengthening, capacity building, and BCC activity implementation • Nodal organization selection and capacity building • Providing HR support (consultants)	• BCC strategy development and approval (e.g., FP repositioning/ UPSACS BCC strategy) • Evidence gathering for strategy and materials development • IPC, mid-media, and mass media materials review and development • Materials development and/or updating • Support to IPC/mid-media campaigns funded through IHBP grants or government funds	• Mobilization of community groups, strengthening of community platforms • Community mobilization plans, materials, messages, training modules development, and buy-in by government • Strengthening of alliances • Engagement of media • Activities to promote and sustain positive behaviors: health workers and community, including recognition system	• Activities specific to vulnerable groups (women, PLHIV and TB patients)

Activities in IRs 2, 3 and 4 will be launched as progress is made under activities in IR 1. In all activities to be undertaken, IHBP is adopting a collaborative, mentoring, "learning by doing" approach with government.

This AWP continues to completion project start-up activities (recruitment of staff; full operationalization of project office in Delhi, Lucknow, and 10 districts; major procurement actions) and technical activities (mainly organization assessments, training and BCC materials reviews, and secondary reviews of existing research studies in the four program elements) initiated in Year 1. It launches major activities in institution strengthening and capacity building, BCC, and community mobilization toward fulfillment of IHBP's four IRs. For Year 2, the AWP focuses more on institution strengthening (IR 1) to enhance capacity of the MOHFW, the NACO, and the MOWCD and their state counterparts so that they can more effectively plan, implement, and sustain BCC activities at the community level (IRs 2, 3, and 4) by the latter part of Year 2. The Year 2 AWP will accelerate activities, especially those under IR 1, to overcome the delays encountered in Year 1 and to prepare for full-scale intensive implementation of BCC and community mobilization activities in Year 3. It must be noted that, as of the date of submission of this AWP, the 10 districts in UP have not yet been selected by USAID and the GOUP. IHBP continues to await a decision on this critical matter.

The narrative below explains activities that are identified in the attached Year 2 AWP table.

Project Management/Operations

During Year 2, activities will be accelerated ensure that IHBP is fully operational at national, state and district levels. Activities involve recruitment for all remaining vacant staff positions and long-term consultants assigned to government, setting up and operating of project offices in Delhi, Lucknow and the 10 districts and procurement actions for office equipment, two vehicles and other requirements. IHBP will also ensure that staff training is updated on USAID-mandated policies like the FP guidelines.

1. *Recruitment of all vacant staff positions in New Delhi, Lucknow, and 10 district offices.* IHBP will continue acceleration of staff recruitment, which was stalled due to the "delay" instruction, to fill all vacant staff positions in the New Delhi and Lucknow offices by the end of the first quarter and all district office positions by the early part of the second quarter. The positions that need to be filled are listed below.

    a) New Delhi Office
        - Institution Strengthening (IS) Chief Technical Advisor (CTA)
        - IS Specialist
        - Advocacy Specialist
        - CTA M&E
        - M&E Specialist
        - M&E Specialist (Population Council position)
        - Private Sector Advisor
        - Grants Administrator

- Procurement Officer
- Finance Manager
- Driver

b) Lucknow Office
   - Technical Director
   - IS Technical Advisor
   - IS Specialist
   - IS Specialist (PCI position)
   - M&E Technical Advisor
   - M&E Specialist
   - M&E Specialist (Population Council position)
   - SBCC Technical Advisor
   - SBCC Specialist
   - SBCC Specialist (PSI position)
   - State Program Field Manager
   - Grants Manager
   - Finance Assistant
   - Administrative Assistant
   - Driver

c) District Offices (10)
   - IS Officer
   - Community Mobilization Officer (PCI position)
   - M&E Officer

For the district positions, final recruitment cannot take place until the 10 districts have been selected.

2. *Recruitment of long-term BCC consultants for national, state, and district levels.* By the first quarter of Year 2, four consultants for national agencies and four consultants for UP agencies will be recruited and seconded. As of this date, the following consultants are planned: two for the MOHFW, two for the NACO, two for the DHFW, two for UPSACS. Recruitment for all district officers and district BCC consultants (one consultant per district) will be initiated in Quarter 1 so that all district vacancies can be filled by Quarter 2.

3. *Set up and operate project offices in Delhi and Lucknow.* IHBP staff are currently occupying temporary office spaces in Delhi and Lucknow. IHBP has signed a lease for permanent space in Delhi and is finalizing negotiations to sign a lease for office space in Lucknow. Factoring in procurement processes for renovation and the time it takes for actual renovation, the permanent IHBP offices in Delhi and Lucknow should be established by the end of Quarter 1.

4. *Set up and operate 10 district offices.* IHBP plans to establish district offices for its staff in the 10 districts. Once the districts are selected, discussions will be held on possible shared space with existing district organizations. By the end of Quarter 2, IHBP expects that all district offices will have been established and operational and that relevant procurement actions will have been completed.

5. *Orientation of IHBP staff and consultants and online training on USAID FP guidelines.* As staff are recruited, FHI 360 will orient staff on the company's and USAID's procedures and processes. IHBP will ensure that all new staff complete the mandatory online USAID FP training and that existing staff completed the required yearly refresher trainings.

6. *Regular project progress meetings.* IHBP will organize regular progress meetings with key FHI 360 and subcontractor staff, USAID, and government focal persons to review progress of activities at national, state, and district levels. Meetings are planned on a semi-annual basis at the national and state levels starting in Quarter 1 and at the district level (which may be grouped according to regions) starting Quarter 3. Field visits may also be included during these meetings.

7. *Semi-annual performance meetings with USAID.* IHBP will meet with USAID on a semi-annual basis (at the end of Quarter 2 and at the beginning of last month of Quarter 4) to discuss progress of activities during the preceding 6 months and plans for the succeeding 6 months.

8. *Finalization of the AWP for Year 2 and Development of AWP for Year 3.* IHBP will finalize the Year 2 AWP during the first month of Quarter 1, incorporating USAID comments. In the beginning of the last quarter of Year 2, IHBP will initiate planning for Year 3.

9. *Development of grants manual.* During the first quarter, IHBP will develop the grants manual. RFPs for IRs 2–4 will be issued to relevant NGOs, civil society organizations, and other private sector groups operating in UP.

10. *Preparation of quarterly progress reports, semi-annual reports and annual reports.* IHBP will prepare these reports on a regular basis, as required by the Task Order.

11. *Award a subcontract to the Public Health Foundation of India (PHFI) to provide TA to IHBP.* IHBP will initiate discussions with PHFI as a first step in developing a subcontract agreement for them to provide strategic TA, including advocacy related to all IRs. The subcontract will be sent to USAID for approval and, upon approval, activities will commence.

A. IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels

During Year 2, we will conduct organization needs assessments (ONAs) and develop institution strengthening plans for submission to USAID for approval. IHBP will strengthen government training institutes responsible for training community-based workers (NIHFW, SIHFW, NIPCCD) to design and deliver improved SBCC training. The project will identify a pool of SBCC trainers at the national, state, and district levels. We will develop or revise SBCC training modules and tools for various categories of health officials at all levels, including community-based health workers (ASHAs, ANMs, AWWs), for more effective use during large-scale trainings in Year 3. The project will also develop and/or update strategic communication plans for HIV/AIDS, FP/RH, MCH, and TB at all levels. These plans will be based on improved use of evidence and will increase focus on mid-media and IPC.

IHBP's advocacy efforts will target government buy-in and financial support to implement: institution strengthening plans; SBCC training and follow-up supervision of Block Health Education and Information Officers (BHEIOs), ASHAs, ANMs, and AWWs; and strategic communication plans for HIV/AIDS, TB, FP/RH, and MCH, including mass production of materials and media airing. IHBP will place BCC consultants in the MOHFW, the NACO, and their state counterpart agencies. Nodal institutions in Delhi and UP will be selected and interventions to enhance their capacity for BCC TA to government will be implemented.

The government agencies referred to in IR 1 are the MOHFW, the MOWCD, the NACO, and their state counterparts; training institutes, including the NIHFW and the NIPCCD at the national level; and the SIHFW at the state level.

Outcome 1 – Organizational structure, management systems and processes, and HR for SBCC strengthened at national, state, and district levels

Eighteen key activities are planned under Outcome 1. They are grouped as follows.

1. *Organization needs assessments and reviews for improved BCC activities (Activities 1.1, 1.3, 1.4).* The ONA for the MOHFW, the MOWCD, and the NACO at national and state levels aims to strengthen IEC/BCC Units and their coordination with program divisions. The ONA exercise will document the current organizational structure of the MOHFW and relevant divisions as it relates to IEC/BCC. Verbal agreement has already been granted by the MOHFW, the MOWCD, and the UP SIFPSA for IHBP to support an ONA for their respective agencies, with a focus on strengthening HR capacity for BCC. Once formal approval is granted by these agencies, IHBP will launch the ONAs. These HR-focused ONAs will review current IEC staffing, responsibilities, activities, available resources, and information flows at national, state, and district levels. It will also cover HR policies and practices, e.g., job descriptions versus actual assignments of BCC/IEC Unit staff, including supervisors, actual staff, and supervisor qualifications; recruitment policies and practices;

performance appraisal systems; staff remuneration and promotion policies; and any other practices that are relevant to effective functioning of the BCC/IEC Unit at the national, state, and district levels. It is expected that ONAs for other agencies (NACO, UP State Programme Management Unit [SPMU], UPSACS) will be initiated in Year 2, Quarter 2. Another activity is a rapid assessment of the supervisory system and actual supervision of frontline workers for IPC, results of which will feed into capacity building of supervisors at district and block levels. An assessment of frontline workers (ASHAs, AWWs, ANMs, directly observed therapy providers, designated microscopy centers, link workers, and Integrated Counseling and Testing Centers [ICTC] counselors) will also be undertaken to assess their current BCC-related practices and to identify capacity building needs. This information will help in refining training modules on BCC for these frontline workers.

2. *Development of institution strengthening and capacity building plans and advocacy activities for government approval and implementation; placement of long-term BCC consultants in government (Activities 1.5, 1.6, 1.7).* Based on the ONAs, we will formulate institutional strengthening plans focusing on HR in collaboration with counterpart government agencies. IHBP will organize consultative meetings and advocacy activities to gain approval of these plans and obtain government resources to operationalize recommendations. BCC consultants to provide day-to-day mentoring support on key aspects of BCC programming will be placed at the MOHFW and the NACO and their state counterpart agencies. Four consultants at the national level and another four at the state level are planned for placement. By the start of Year 2, one BCC consultant for DHFW's NRHM program assigned to the SIFPSA will be recruited. The other consultants are expected to be working in their assigned agencies by the second quarter of Year 2. One BCC consultant for each district will also be recruited by the third quarter.

3. *Rapid assessments of existing M&E systems; development of tools, including BCC indicators, to strengthen M&E for BCC at all levels; support to district- and block-level officials to compile and analyze BCC-related information (Activities 1.2, 1.10, 1.12, 1.13).* These rapid assessments will review the existing M&E for the BCC system currently followed in the IEC/BCC Units and in the program divisions of the MOHFW and the NACO and their state counterparts. Based on the review, IHBP will develop and/or update BCC indicators and a system for tracking them. The project will also undertake advocacy activities to obtain acceptance of these indicators and the tracking system by government at national and state levels. We will also develop M&E tools relevant to the districts and blocks and provide support to district and block officials in their effort to adopt and operationalize the indicators and tracking system.

4. *Orientations on SBCC for health program officials and policy makers at national, state, and district levels and for relevant training institutes at national and state levels; exposure visits to states (Activities 1.8, 1.9, 1.16).* These orientations will be conducted for IEC/BCC Unit staff and program division staff of the MOHFW, the NACO, and the MOWCD at national and state levels. IHBP will organize exposure visits for selected officials to states that have

fully functioning IEC/BCC cells or implemented best practices on BCC in health so that understanding of and commitment to BCC can be enhanced.

5. *Support to improve coordination mechanisms on BCC (Activities 1.14, 1.17, 1.18).* IHBP will support quarterly district-level coordination meetings in each of the 10 districts that will be convened by the district magistrate, establishment of a BCC partners' forum at the national level and in UP, and organization and regular meetings of PAGs at national and state levels. By the first quarter of Year 2, the project will establish a PAG at the national level, consisting of representatives from stakeholder ministries, government agencies, USAID/India, USAID implementing partners, and other stakeholders. The PAG will be an advisory cum advocacy body, which will primarily provide strategic guidance to the project in technical areas related to BCC, provide access to key documents relevant to the project, and function as a champion for the project and its objectives. A similar body with a matching purpose called the State Project Advisory Group (SPAG) will be established at the state level. The PAG and the SPAG will not be involved in approving plans, activities, and budgets. The project team will draft written Terms of Reference (TOR) for the advisory groups and will share it with USAID/India before finalizing their contents and constituents.

6. *Advocacy with state and district officials to include BCC training in training calendars of frontline workers (Activity 1.15).* IHBP will pursue consultative meetings with UP state and officials of the 10 selected districts to heighten their commitment to BCC and include BCC training in the regular training calendars of frontline workers.

7. *Support to the MOHFW and the NACO and their state counterparts to improve media planning and monitoring of media campaigns (Activity 1.11).* IHBP will assist the MOHFW and the NACO and their state counterparts in enhancing their capacity for more effective media planning and monitoring. This will be done through on-the-job mentoring and hiring of a media agency.

Outcome 2 – SBCC training developed and conducted for improved competencies in evidence-based SBCC at national, state, and district levels

Eight activities fall under this outcome. They are categorized as follows.

1. *Support to the NIFHW and the SIHFW in developing SBCC training modules and courses for various categories of personnel; integrating these courses in their training calendars and training of trainers at the national, state, and district levels (Activities 1.19, 1.20, 1.21, 1.23, 1.24).* In collaboration with these training institutes, IHBP will develop or update BCC/SBCC training modules and courses. Results of needs assessments for capacity building for ASHAs will be utilized to develop or update modules to revise or update BCC training for ASHAs. The NIHFW is currently conducting some IEC/BCC training for various health program staff at the state level. The goal is to develop or update, formalize, and integrate SBCC courses as part of the regular course offering of the NIHFW and the SIHFW for various government staff categories (IEC Unit staff, health program staff, M&E

staff, district health officials, BHEIOs, frontline workers). IHBP will support the promotion of these courses to national and state government agencies.

2. *Development of training strategy and advocacy to strengthen BCC in VHNDs and Village Health and Sanitation Committees (VHSCs) (Activity 1.22).* Based on the capacity building needs assessment of ASHAs, AWWs, and ANMS (*Activity 1.4*) and the review of VHNDs and VHSCs planned under IR 2, IHBP will develop, in consultation with government, a strategy to strengthen frontline workers' skills in the organization of VHNDs and other community platforms. IHBP will also advocate that this strategy be included in the state and district Program Implementation Plans (PIPs).

3. *Conduct of workshops and mentoring on specific SBCC competencies for IEC staff at national, state, and district levels (Activities 1.25, 1.26).* IHBP will conduct workshops and on-the-job mentoring to IEC Unit and program staff, through project staff, BCC consultants, and the nodal institutions, on specific aspects of SBCC planning, implementation, and evaluation. This will include enhancing specific skills, e.g., undertaking situation analysis and evidence reviews for planning, developing creative briefs and communication materials, and planning mid-media and IPC activities. For district-level staff, IHBP will support the SIFPSA and SPMU-NRHM in training district-level trainers to cascade similar SBCC workshops and sessions. Flexibility will be an inherent characteristic of these workshops that will depend on the situation. They can be held as one workshop or as multiple sessions to be incorporated in the regular coordination meetings of ASHAs and ANMs. To supplement learning gained from these workshops, IHBP will provide mentoring support to IEC staff through its district project staff, BCC consultants, and the selected nodal agencies.

Outcome 3 – SBCC nodal institutions identified and strengthened at the national level and in Uttar Pradesh

During Year 2, IHBP will select nodal institutions and develop their capacity to provide TA to government agencies on BCC. There are five activities to bring this about.

1. *Completion of the scoping study of potential nodal organizations initiated in Year 1 (Activity 1.27).* This study will identify potential nodal institutions in New Delhi and UP based on criteria to be agreed upon with USAID and government. As discussed in the Year 1 work plan, these institutions can be NGOs or private or quasi-government agencies that have existing capacity on BCC and have strong potential to provide TA to government in various aspects of planning, delivering, and evaluating BCC health programs. IHBP will conduct an analysis of the strengths and weaknesses of these identified nodal institutions and, based on this analysis, recommend those that can be selected as nodal agencies. Final selection will be undertaken in collaboration with USAID and government. IHBP will sign a subcontract with the selected nodal agencies at national and state levels for capacity building activities. By the second quarter of Year 2, nodal agencies will be selected and subcontracts with them will be signed.

2. *Conduct of ONAs of selected nodal agencies and, based on these assessments, development of capacity building plans (Activities 1.28, 1.29).* IHBP will conduct an organization and capacity needs assessment of the final selected nodal agencies. Results will inform specific areas of capacity building and organization strengthening interventions that IHBP can pursue.

3. *On-the-job training and mentoring of nodal agency staff on various aspects of SBCC planning, implementation, and evaluation, and on provision of TA to government (Activities 1.30, 1.31).* Starting in the third quarter of Year 2, IHBP will carry out capacity building activities to enhance the selected nodal agencies, using formal learning sessions, on-the-job training, and mentoring. Nodal agencies will gradually assume responsibilities for TA as their capacities improve.

B. IR 2: Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers at district, state, and national levels

As described in the previous section, IR 1 activities will, among other things, influence organizational changes in the MOHFW, the NACO, the MOWCD/ICDS, government training institutions, and their state and district counterparts that will lead to more effective planning and heightened resource allocation for mid-media and IPC, improved capacity building of frontline workers on BCC, and guidelines for fortified community platforms, namely VHNDs and VHSCs. As IR 1 activities are demonstrating results, IR 2 activities will be initiated and expanded. IR 2 activities will assist in: formulating or updating evidence-based BCC strategies on HIV/AIDS, FP/RH, TB, and MCH; developing or updating BCC materials accordingly; invigorating mid-media and IPC activities at the community level through provision of support (communication materials, job aids, on-the-job training, mentoring) for IPC activities; and supporting monitoring and supervision of frontline workers by district and block officials.

Outcome 1 – Evidence-based strategic SBCC plans integrated as part of program plans for HIV/AIDS, FP/RH, TB, and MCH

Nine activities are planned to achieve this outcome.

1. *Active participation and support in development of IEC/BCC plans for the NACP IV, NRHM II, and ICDS Program of the NACO, the MOHFW, and the MOWCD and their state counterparts (Activity 2.1).* To influence government BCC plans on HIV/AIDS, FP/RH, TB, and MCH, IHBP will participate in the planning process for the NACP, the NRHM, and the ICDS. During Year 1, IHBP actively participated in the IEC working group for NACP IV and sponsored a 2-day small group working meeting to finalize the IEC component of NACP-IV based on results from the working group. NACP-IV strategy is not final or approved by the GOI; therefore, IHBP plans to continue active engagement in this dialogue. During Year 2, IHBP will actively pursue continued participation in these government planning processes and exert efforts to influence BCC planning for TB, FP/RH, and MCH both at national and state levels.

2. *Active participation in consultations on PIPs under the NRHM and the NACO to strengthen BCC focus on mid-media and IPC and to advocate for government funding accordingly (Activity 2.2).* IHBP will participate in the PIP consultations at national, state, and district levels to influence improved planning and increased budgetary allocations for evidence-based BCC plans; activities to increase focus on mid-media and IPC; and training and supervision of frontline workers on BCC.

3. *Assistance in developing a BCC strategy for HIV/AIDS, FP/RH, TB, and MCH at national and state levels (Activities 2.3, 2.6, 2.7, 2.8, 2.9).* IHBP will provide support to government in developing or updating BCC health strategies under the four program elements. As earlier stated, IHBP provided assistance in development of the IEC strategy for NACP-IV. To respond to UPSACS's request, IHBP has initiated a communication needs assessment comprising a review of current research findings, secondary analysis of data, and selected qualitative research studies on HIV/AIDS. Although UP is a low-prevalence HIV/AIDS state, there are population segments exhibiting risky behaviors that could spread transmission. UPSACS plans to promote healthy sexual practices among these high-risk groups, e.g., migrants, truckers, MSM, injecting drug users, and female sex workers. IHBP will launch qualitative research studies to probe risky behaviors of truckers and migrants regarding HIV/AIDS and barriers to the availability of ICTC services by pregnant women. UPSACS will seek other funding sources for qualitative studies among the other high-risk groups. IHBP plans to organize a workshop in January 2012 to develop the initial strategy based on the research review and secondary data analysis. Based on results from the qualitative research studies, the BCC strategy will be revised and finalized in the course of Year 2 through consultation meetings and workshops with stakeholders. By the end of Year 2, it is expected that a full-blown final UPSACS BCC strategy would be approved and launched with government support. In collaboration with the MOHFW, IHBP has initiated development of an SBCC nationwide strategy to reposition FP from limiting to birth spacing. IHBP will continue technical support to operationalize this strategy. IHBP expects to influence national and state BCC strategies in TB and MCH in the early part of Year 2.

4. *Conduct of qualitative and operations research studies to gather evidence for more effective BCC planning and implementation in the four program elements (Activity 2.5).* A research agenda is currently being finalized for implementation in UP. The studies include qualitative research to probe barriers and facilitators to desired behaviors, e.g., use of traditional FP methods, reasons for discontinuation of modern FP spacing methods, misconceptions and fears of side effects regarding contraceptives, and gender violence as a barrier to health-seeking behaviors. One operations research study will be conducted to investigate more appropriate channels to reach various audience segments, including males, vulnerable groups, community influentials, frontline workers (e.g., whether mobile phones are effective channels to reach men and/or women). Another operations research study will determine whether the systematic screening instrument, which was developed by the Population Council to improve screening, assist ANMs in identifying various health care needs of a single client, and help ANMs provide a comprehensive package of services, can be feasibly mainstreamed in regular ANC services in UP. Findings from these research studies will

provide evidence for improved message and materials development, selection of more effective communication channels for specific target groups, and use of tools for health providers.

5. *Advocacy with district officials in the 10 IHBP focus districts to develop, strengthen, and operationalize a BCC events calendar for the district (Activity 2.4).* IHBP will undertake consultative meetings and other activities to obtain buy-in and commitment from the district magistrate and other key district health officials in developing and operationalizing the BCC events calendar in their respective districts.

Outcome 2 – IP, mid-media, and mass media strategies and materials on HIV/AIDS, FP/RH, TB, and MCH updated and improved

There are three activities that aim to produce this outcome.

1. *Review of mid-media and IEC/IPC strategies and materials being used by frontline workers for HIV/AIDS, FP/RH, TB, and MCH (Activity 2.10).* This continues and will follow to completion a group of activities initiated in the last quarter of Year 1, namely, review of existing IEC/IPC strategies and materials and of review of best practices on BCC in India and neighboring South Asian countries. These reviews consider efforts undertaken by USAID and other donor-funded projects at the national level and in UP. As stated in the Year 1 AWP, IHBP acknowledges that there are ongoing initiatives in UP to strengthen mass media, mid-media, and IPC for MCH, FP, and HIV/AIDS. USAID partners, including the Maternal and Child Health Integrated Program (MCHIP), the Vistaar Project, the Innovations in Family Planning Services (IFPS) Innovations in Technical Assistance Project (ITAP), the Technical Support Unit of the UPSACS, the Maternal and Child Health Sustainable Technical Assistance and Research (MCH STAR) Project, the Bill and Melinda Gates Foundation (BMGF)-funded Sure Start and Manthan Projects, and the UNICEF-led TA in the Comprehensive Child Survival Program, are actively supporting implementation of NRHM and NACP-III in UP. At the national level, several development partners, including the Department for International Development (DFID), USAID partners, BMGF partners (e.g., IntraHealth, CARE, and PATH), United Nations agencies (especially UNICEF, the United Nations Development Programme [UNDP], and the United Nations Population Fund [UNFPA]), international NGOs (e.g., International HIV/AIDS Alliance), and national NGOs (e.g., the Hindustan Latex Family Planning Promotion Trust [HLFPPT] and the Mamta Health Institute for Mother and Child [Mamta - HIMC]), are engaged in strengthening IEC/BCC activities under the NRHM and the NACP. Once the reviews are completed, IHBP will disseminate findings to the government and aforementioned agencies and will hold discussions with the government on the need to update or develop new materials. The recommendations will also take into account results of needs assessments conducted among frontline workers under IR 1, Activity 1.4.

2. *Assistance to develop new or improve/update mass media, mid-media, and IPC strategies/plans and develop/update prototype materials and IEC/BCC products (Activities*

2.11, 2.12). With progress in development or revision of evidence-based BCC strategies, IHBP will provide support to the relevant government agencies in developing new or improving/updating mass media, mid-media, and IPC materials. As earlier described, IHBP will support national and state government in developing a comprehensive SBCC strategy for HIV/AIDS, FP/RH, TB, and MCH. The project will advocate that these plans are funded in the national and state PIPs. IHBP has already commenced TA to the UPSACS and the MOHFW in formulating the UP HIV/AIDS BCC strategy and the SBCC strategy to reposition FP, respectively. These two activities under IR 2 will focus on developing new or refining/updating IEC/BCC materials, including mass media (for national agencies), mid-media, and IPC as part of implementing the comprehensive SBCC strategy for the health program involved.

It is expected that materials development and production for the other health program elements will follow a similar approach, i.e., BCC strategy development/updating as basis for mass media, mid-media, and IPC strategy/materials development/updating. However, as agreed to with USAID, IHBP may accede, on a selective basis, to government requests for development or production of IEC/BCC materials in the absence of a more strategic BCC plan for the health program in question *to generate deeper commitment and buy-in from government.* Moreover, these discrete requests for materials development provide opportunities for joint planning and capacity building of government counterparts in more strategic, evidence-based design and development of materials. In line with this perspective, IHBP agreed to UPSACS's request for support in developing and producing a 3-minute film on stigma and discrimination targeted at youth in UP.

Outcome 3 – IPC and mid-media activities/campaigns implemented by government and private sector partner organizations

There are two activities that come under this outcome.

1. *Two types of IPC and mid-media community-level activities are envisioned for implementation in Year 2: those funded by IHBP under its grants program and those funded by government or other donor sources (Activity 2.14).* The IHBP grants will be awarded to NGOs and civil society groups to implement innovative IPC and mid-media activities in the 10 UP districts. Aside from funding, IHBP will provide technical support to grantees to enhance their capacity to manage the grant awards and coordinate with government. IHBP will provide mentoring support to district and block IEC officials in planning and overseeing implementation (through M&E and supportive supervision) of mid-media and IPC activities funded by government through PIPs or other budget sources. These latter activities are expected to be executed by government health providers and frontline workers. Mentoring will be provided by the IHBP district-level staff and district BCC consultants. It must be noted that the specific BCC activities under Activity 2.14 are the core IPC and mid-media activities that will result in healthy behaviors by various target groups, particularly individuals, families, and health providers.

2. *Quantitative study to determine KAP among health providers, frontline workers, and general populations (Activity 2.13).* To provide baseline information to track changes in KAP as a result of these activities, a quantitative study of health providers and frontline workers, and of specific target groups (e.g., couples of reproductive age, truckers and migrants, community leaders and influentials, other family influentials like mothers-in-law), will be conducted in the early part of Year 2 on HIV/AIDS, FP/RH, TB, and MCH. The health provider and frontline worker KAP study will be done as part of Activity 1.4 under IR 1 (capacity needs assessment of health providers and frontline workers on BCC). The project is drafting the study design and tools to share with the Institutional Review Board (IRB) committees for their approval by the first quarter of Year 2. Data pertaining to the performance of institutions, providers, and health education personnel will be collected. Two types of information will be collected: information on BCC processes in practice and KAP on the four program elements.

Outcome 4 – IPC activities regularly monitored and feedback provided to ASHAs, ANMs, and AWWs

Outcome 4 activities will be initiated as progress is made under IR 1 in developing the capacity of district and block officials for M&E and supervision, giving them tools to facilitate performance of these functions, and obtaining commitment to implementing the M&E system at block and village levels. IHBP will undertake the following activities under IR 2 to achieve this outcome.

1. *Technical support to ASHASs, AWWs, and ANMs on a monitoring and feedback mechanism (Activity 2.15).* IHBP will provide TA, through its district-level staff and consultants, to these frontline workers in monitoring BCC activities in the communities where they operate. This assistance will be done through mentoring and learning by doing approaches. Regular coordination meetings of these frontline workers at block level will be used as opportunities to discuss results of monitoring, problems encountered, lessons learned, and succeeding activities. These meetings will also be used to recognize positive performance.

2. *Mentoring, on-the-job support to district and block supervisors in using tools for M&E and supervision (Activity 2.16).* IHBP district-level staff and consultants will mentor and provide on-the-job support to BHEIOs in monitoring and supervising BCC activities of frontline workers and communicating their feedback to their supervisees to sustain good performance and work on areas of improvement. A system will be devised to be used to observe supervision encounters between supervisors and supervisees. These encounters will generate observations on supervisor performance that will be discussed with the supervisors in question. Coordination meetings of BHEIOs at district levels will be used as channels to discuss issues and problems encountered on M&E and supportive supervision and how to address these. These meetings will also be used to recognize positive performance.

3. *Assist district trainers in training supervisors of ASHAs, ANMs and AWWs (Activity 2.17).* IHBP staff at the district level will provide technical support in district- and block-level

training of supervisors of frontline workers in supportive supervision of BCC functions. These trainings are expected to be funded by government as a result of advocacy activities.

C. IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors

IR 3 activities aim to invigorate community platforms and strengthen and mobilize community groups to promote sustained healthy behaviors. Achievement of IR 3 is closely linked to progress of activities under IR 1, which will develop and operationalize a training plan for frontline workers and an effective M&E and supportive supervision system for these workers, and will boost coordination at the district and block levels.

Outcome 1 – Organization and coordination of communication platforms for IPC and/or mid-media at village level strengthened

There are four activities under this outcome.

1. *Desk review and field visits to assess VHNDs and VHSCs (Activities 3.1, 3.2).* IHBP will conduct a desk review of existing literature on VHNDs (current guidelines, research reports, review reports), which will be supplemented by field visits to observe competencies of ASHAs, AWWs, and ANMs during VHNDs. Information will be gathered on actual ways by which VHNDs are coordinated at the village level. IHBP will also take into account existing evidence from other projects (e.g., Vistaar) that have implemented VHND-related research or interventions.

2. *Development of revised guidelines and discussion/advocacy with district officials for adoption of guidelines (Activities 3.3, 3.4).* Findings from the review undertaken under Activities 3.1 and 3.2 will be used to develop or revise guidelines to strengthen organization and evaluation of VHNDs by ASHAs, ANMs, and AWWs. We will undertake consultation meetings and discussions with district officials, led by the district magistrate for adoption of these guidelines in the 10 districts.

Outcome 2 – Community groups mobilized and trained to organize or facilitate IPC and mid-media activities at community level

There are five activities under this outcome.

1. *Evidence review on promising practices and development of strategy on community mobilization (Activities 3.5, 3.6).* We will undertake a desk review of good practices on community mobilization for the four program elements to develop strategies applicable for the UP situation. Results of the review will be disseminated. The strategy development will be done in collaboration with state and district officials during consultative meetings and workshops.

2. *Implementation of community mobilization activities funded by IHPB grants (Activities3.7).* IHBP will award grants to NGOs and civil society organizations for execution of innovative community mobilization activities. IHBP will provide technical and funding support to enhance grantee capacity for implementation. IHBP will monitor implementation of grants. It must be noted that results on changes in community practices and norms are expected to be delivered through implementation of interventions under Activity 3.7.

3. *Support to community mobilization activities funded by government and other donors (Activities 3.8, 3.9).* Aside from community mobilization activities funded by IHBP grants, project advocacy efforts are expected to result in government funding for other community mobilization interventions. For these activities, IHBP will provide technical support through its district staff and district BCC consultants to district- and block-level government staff on M&E and supervision. We will create and share monitoring and reporting templates to assist in the implementation of these activities.

Outcome 3 – Advocacy and community mobilization plans, materials, messages, and training modules developed and pretested

There are seven activities under this outcome.

1. *Review and development/updating of existing materials (Activities 3.10, 3.11, 3.12).* Part of the IEC/BCC materials review described in Activity 2.1 is a review of advocacy materials for the national and state levels. Results of the review will be used to develop an advocacy strategy through stakeholder consultations. Based on the strategy, materials will be updated or new ones created, if necessary

2. *Identification and capacity building of health champions and spokespersons (Activities 3.13, 3.14, 3.15, 3.16).* The project will identify community influentials. They can be formal or informal community leaders, celebrities, government officials, sports or media personalities, community members, religious leaders, and/or politicians who are respected by the communities who can shape public opinion on certain issues. From this group of influentials, IHBP will identify and select champions and/or spokespersons for healthy behaviors. These champions and spokespeople will be trained to authoritatively and persuasively speak in public about specific health issues and promote healthy behaviors among the audience segments or constituencies they influence.

Outcome 4 – Existing alliances strengthened and new alliances formed, if necessary

Four activities will work toward this outcome.

1. *Scoping of alliances and networks in the four program areas, capacity needs assessment, and action plans for capacity strengthening on BCC (Activities 3.17, 3.18, 3.19).* IHBP will conduct a study to identify and map existing alliances for FP/RH, HIV/AIDS, TB, and MCH at the national level and in UP. The project recognizes that there are already several strong

alliances that advocate for issues within these four program elements. From this list of alliances, IHBP will short-list existing alliances and networks whose objectives are aligned with the project. The project will conduct an assessment of the strengths and needs of these existing alliances regarding BCC. This assessment will provide information on such areas as use of evidence and frameworks in planning activities, trained spokespersons, M&E systems to assess results of activities, and coordination at national and state levels. From this assessment, an action plan will be developed, in collaboration with these alliances, to strengthen their BCC-related capacities.

2. *Implementation of capacity building activities for alliances and networks (Activity 3.20).* With the action plans finalized and buy-in generated, IHBP will commence capacity building activities for selected alliances at national and state levels. These activities could be in the form of training of spokespersons, developing capacity for conducting qualitative research studies, enhancing presentation skills of alliance leaders, and developing and using visual aids.

Outcome 5 – Media engaged as supportive partner at national and state levels

Media in this context covers individuals working in print or broadcast (TV, radio) or new media who are in a position to communicate messages on healthy behaviors targeting the public or specific audience segments. Engagement of media is key to creating positive norms and a supportive social environment for healthy behaviors.

Four activities fall under this outcome grouped as follows.

1. *Media mapping (Activity 3.21).* The media mapping study initiated in Year 1 will be completed in Year 2, Quarter 1. The media mapping will describe the universe of various media channels at the national level (emanating from Delhi, Mumbai, Kolkata, and Chennai) and those in UP, namely, TV, radio, community radio, print media (newspapers, magazines), new media (mobile phone and Internet providers, websites, and social media sites, such as Facebook). It will identify specific TV or radio stations, print publications, or new media channels/forms by name, category or area of specialization, type of ownership, name of key officers, readership or circulation, reach, target audience segment, specific health issues or advocacies promoted (if any), and languages used. The mapping will also identify influential media personalities (TV or radio celebrities, show hosts or news anchors, newspaper or print columnists, editors or writers, other popular individuals) who can be mobilized to speak or write about health issues.

2. *Development of media advocacy plans (Activity 3.22*). IHBP will develop advocacy plans, in collaboration with government counterparts, based on the results of the media mapping exercise. Part of the media advocacy plan will be identifying and selecting spokespersons e.g., media personalities, newspaper columnists, and news reporters, who can be trained and mobilized to be champions and spokespersons.

3. *Creation of stories for media dissemination (Activities 3.23, 3.24).* IHBP will develop compelling stories on various health issues that will be disseminated in various formats for media to print or air. A communication or public relations agency will be hired to craft and finalize the stories, regularly coordinate with specific media influentials, and monitor media placements. Cost estimates of free print space or air time used to relay the stories or messages will be treated as part of leveraging.

Outcome 6 – Positive behaviors by health workers and community members recognized and reinforced

The activities under this outcome comprise development or strengthening of recognition schemes that "reward" performance of positive behaviors by health providers and frontline workers as well as community members and leaders. The schemes will be non-monetary and could take the form of plaques of recognition awarded to ASHAs, ANMs, and/or AWWs by the district magistrate during coordination meetings; congratulatory messages for frontline workers or community leaders aired through radio or TV; and pins or medals to males who accompany their wives for ANC visits; among others.

The activities to realize these schemes are as follows.

1. *Review of existing community-based recognition schemes and development of guidelines to strengthen existing schemes or formulate new ones, if necessary (Activities 3.25, 3.26, 3.27).* There are various schemes and systems currently being operationalized in UP and other states. IHBP will review these schemes through a desk review of existing documentation and field visits to selected areas. The results of this review will be discussed with state and district officials. IHBP will discuss operationalization of schemes (existing or new) with district officials to generate buy-in.

D. IR 4: Vulnerable communities empowered to seek health services and products

IR 4 activities target vulnerable groups, particularly women that are not empowered to access health services; PLHIV; and TB patients that are deterred from seeking diagnosis and initiating and sustaining treatment due to stigma and discrimination held by health providers, frontline workers, and community and family members, especially males. IHBP will aim to empower these groups by developing their self-efficacy to assert their rights to health care, by addressing stigma and discrimination issues among health providers, frontline workers, and community members, and by supporting innovative interventions that will create a more accepting and supporting family and community culture. IHBP will also reach out to men to encourage their involvement in family health issues and to improve women's role in decision making.

Outcome 1 – Evidence reviewed and strategies and materials prepared

There are three activities under this outcome.

1. *Desk review and qualitative research on vulnerable groups and development of stigma and discrimination reduction strategies (Activities 4.1, 4.2, 4.3).* The review of successful interventions in reducing stigma and discrimination among these vulnerable groups initiated in Year 1 will be completed by the first quarter of Year 2. In Year 2, qualitative research studies to probe various aspects of stigma and discrimination will be implemented. Among the subject areas to be investigated are gender violence as a barrier to women seeking health services; stigma and discrimination among health providers and frontline workers and among community members on HIV/AIDS and TB; barriers preventing males at high risk for HIV/AIDS from seeking diagnosis or using condoms; and barriers preventing HIV/AIDS and TB patients from continuing treatment. Results of the desk review and qualitative research will form the basis for developing strategies to address stigma and discrimination among health providers, community members, and vulnerable groups themselves. Strategies will be developed at the state level.

Outcome 2 – Knowledge and ability of health providers and frontline workers on gender, stigma on HIV/AIDS, TB, and other discrimination forms improved

Three activities fall under this outcome.

1. *Advocacy for incorporating gender and discrimination in district-level trainings and other planned IEC events (Activity 4.4).* Based on the strategy developed, advocacy targeting state and district-level officials will be undertaken to convince these officials to integrate gender and discrimination in trainings of health providers and frontline workers. Advocacy will be realized through dissemination of research results described above, and presentations that will demonstrate the people's right to services, for example.

2. *Revise or create modules for sensitizing health providers and frontline workers on stigma and discrimination and training of district teams and IHBP grant awardees on modules (Activities 4.5, 4.6).* Modules will be revised or new ones developed, as necessary, to sensitize health providers and frontline workers on stigma and discrimination and to develop their skills on how to address them. Sensitization will mostly entail participatory sessions aimed at heightening trainees' awareness of their own stigma and discrimination issues and eliciting commitment to address them. Additionally, these modules will hone the trainees' skills in detecting stigma and discrimination, whether reflected in subtle or apparent ways, and in how to address them. This could be as simple as encouraging women to sit in front of the group during a community meeting or providing opportunities for a spokesperson from positive networks to speak with the general population, or could be more complex like touching a PLHIV. IHBP will train its counterpart district teams on the use of the sensitization modules and monitor actual implementation at the block levels. Training will

be provided to IHBP grantee organizations that will implement interventions to reduce stigma and discrimination as per Outcome 4 below.

Outcome 3 –KAP of men are improved

An underlying factor to stigma and discrimination is lack of decision making capacity, particularly among women. Gender is an underlying factor preventing women from accessing health services whether it is for FP, HIV/AIDS, or TB, because men have (and women do not have) the power to decide on these matters. In some areas, gender biases prevent women from travelling alone to seek health services.

1. *Undertake state-level consultations to generate male involvement (Activity 4.7).* This activity aims to generate male involvement in their wives' and their family's health, e.g., in FP, and to improve their attitudes regarding women's accessing diagnostic and therapeutic care for FP, HIV, and TB, or other important services like ANC. Under this activity, IHBP will use findings of the research studies conducted in Activities 2.5 (qualitative research studies) and 2.13 (baseline KAP among male), qualitative researches probing beliefs and attitudes among truckers and migrants on HIV/AIDS, and barriers among pregnant women to accessing ICTC services. Relevant results will be synthesized and presented during state-level consultations to evolve strategies addressing men. This set of activities is planned for the third and fourth quarters of Year 2 and actual implementation will be launched in Year 3.

Outcome 4 – Programs to reach vulnerable groups, improve their self-efficacy, and empower them using a rights-based approach

1. *Activities to reach vulnerable groups through IHBP grants and through government funds (Activity 4.8).* Two funding sources are envisioned: IHBP grants for innovative interventions and government funding through PIPs and other sources. IHBP will fund and provide technical support to local NGOs and civil society organizations that propose innovative BCC projects to reach vulnerable groups and improve their self-efficacy. Possible interventions include activities that will identify, train, and mobilize women, PLHIV, and TB patients to make testimonials and become spokespersons for vulnerable groups; mid-media activities to sensitize community members on stigma and discrimination; sensitization sessions for Panchayati Raj Institution (PRI) members and community influentials; and film showings followed by group discussions among men, couples, or family members together. Government funding for stigma and discrimination projects are also expected. For these interventions, IHBP will provide technical support through mentoring or district and block officials to enhance skills in M&E, supervision, and reporting.

Knowledge Management

Knowledge management (KM) is about enabling organizations and practitioners to work smarter by eliminating redundancies. KM is an integral part of IHBP. The goal of KM is to ensure that information is flowing and knowledge is developed and shared appropriately, both internally across the program and externally to partners and institutions at the central level and across

selected districts in UP. IHBP KM activities in Year 2 will launch information dissemination activities through various channels and support government in strengthening its knowledge-sharing systems on BCC.

Outcome 1 – Systems established to disseminate and share information with key audience

The following activities will be conducted under Outcome 1.

1. *Launch and operationalize project website (Activity 1.1).* In October 2011, IHBP will launch the project website for public access. After the launch, the project will regularly maintain and promote use of the website as a key information resource on BCC by partners and stakeholders.

2. *Train IHBP staff and subcontractors on using and updating the IHBP Intranet (a sub-component of the project website) (Activity 1.2).* A userid/password-based Intranet (internal site) will be an important sub-component of the project website. IHBP will conduct trainings to help staff and subcontractors learn to use the Intranet site for knowledge sharing and information dissemination.

3. *Produce and disseminate the IHBP quarterly newsletter (Activity 1.3).* In Year 2, we will produce and disseminate the IHBP newsletter on a quarterly basis. As activities progress, IHBP will showcase success stories in the newsletter. We will also develop a web-based e-newsletter.

4. *Conduct review and recommend new and innovative media for knowledge sharing and dissemination (Activity 1.4).* Use of new and innovative media has always played a significant role in BCC, especially in reaching multiple audience segments. As a KM function, IHBP will review recent innovations in new media and assess their suitability for BCC communication. The project will then recommend suitable media and new tools.

5. *Synthesize and disseminate recent innovations in BCC (Activity 1.5).* In the course of their work, IHBP staff and subcontractors learn about interesting innovations/practices in BCC. IHBP will periodically shortlist and synthesize promising state-of-the-art innovations/resources in BCC for health and disseminate monthly "alerts" to interested stakeholders through a "BCC Resource Bulletin."

Outcome 2 – KM and knowledge-sharing skills of key stakeholders strengthened to create knowledge and use information

The following activities will be undertaken under Outcome 2.

1. *Map and review current information vehicles (information dissemination systems) of ministries and government bodies (Activity 2.1).* Currently, some ministries and government agencies have well placed knowledge-sharing vehicles, e.g., websites, newsletters, and some

do not. IHBP will map and review existing information dissemination systems and help strengthen them.

2. *Support ministries and government agencies in setting up and strengthening IEC/BCC Resource Centers (virtual and/or physical) (Activity 2.2).* IHBP will support ministries and government bodies in streamlining KM activities. This will eventually contribute to strengthened institutional capacities in SBCC-related information management, for instance, creating SBCC hubs/gateways and other channels. In Year 1, the MOHFW and the MOWCD requested IHBP support in strengthening their respective BCC or Information Resource Centers. IHBP has drafted a framework for launch and operationalization of the MOWCD Resource Center called the Nutrition Resource Platform. IHBP expects to be involved in moving activities forward in Year 2.

3. *Help in systematic dissemination of government communication outputs developed under IRs 1, 2, 3, and 4 with support from IHBP (Activity 2.3).* In the course of implementation of Year 2 activities, IHBP will support several BCC-related outputs or products, e.g., research studies, reports on assessments and best practices, review of training and IEC/BCC materials, policy presentations, training modules, job aids, and BCC materials. IHBP will help the government develop a strategic dissemination plan and provide support to the selection of appropriate distribution mechanisms/channels.

4. *Identify and operationalize good KM practices (Activity 2.4).*

Leveraging

Outcome 1 – Full-time IHBP leveraging staff hired and local consultants as needed by FHI 360 and PSI

Based on the approved budget and staffing pattern, IHFP has initiated recruitment of a full-time staff person for the Delhi office. In addition, headquarters leadership for leveraging will be provided by a senior consultant (replacing the staff person who was originally named in the proposal, but who is not available). This core team will be supported, as required, by consultants (FHI 360 and PSI) with specific expertise or attributes that will further the leveraging agenda.

Outcome 2 – Strategy developed and validated through consultation with potentially interested partners

The three activities in this outcome will set the stage for the leveraging program over the remainder of the project. In Year 1, a desk review was conducted by Sorrento Health that addressed the current situation in India related to corporate social responsibility, PPPs, and the potential mechanisms to engage the private sector in additional health programming. This will be the foundation from which the strategy will be developed. In-person meetings are crucial to expand those initial insights and develop personal relationships. Two trips are planned by the leveraging consultant to meet with potential partners and various corporate umbrella organizations, such as FICCI, as well as to plan and conduct some potentially large-scale

meetings to garner private sector interest in additional health programming. Based on these initial meetings, a strategy and timeline will be developed. As organizations buy into leveraging activities, memorandums of understanding will be developed with clear understanding on the expectation of each organization.

Outcome 3 – Implement leveraging strategy that targets health-related support at the national or UP level and includes private, commercial, and nonprofit sectors and government contributions

Activities under this outcome will include a wide range of efforts that were elaborated on in our proposal submission. A few examples of mechanisms to start leveraging activities include seed money for new activities, matching funds to increase coverage areas of sales forces, and sharing or providing BCC materials and messages that can be disseminated through private sector networks. Potential activities include cash contributions that can be programmed for a transport program for facility-based deliveries; free truck messaging; adding health messages into existing health initiatives, such as the hotline run by the Royal Bank of Scotland; additional mass media programs contributed for national airing by government; working with commercial organizations to develop low-cost products and expanding access for them; encouraging PR firms and advertising agencies to provide internships for BCC staff from nodal organizations; expanding health initiatives at the workplace to create partnership hubs of small industries/organizations supported by a large organization to ensure sustained preventative health services (AIDS counseling and testing; immunization for mothers and children, oral rehydration therapy/zinc, etc.); having local NGOs and alliances tap their volunteer networks to further communicate project messages with target audiences; and development of a fellowship program to provide academic training

MILESTONES AND WORK PLAN FOR PROJECT YEAR 2 (October 1, 2011 to September 30, 2012)

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budget by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/ RH	MCH	HIV/ AIDS	TB
Project Management/Operations																			
0.1	Recruit all project staff for Delhi, Lucknow, and district offices				All vacant positions in the project organigram filled with qualified staff									Request Task Order amendment to waive requirement for USAID approval of all technical positions except key personnel	$40,587	$15,829	$5,276	$14,206	$5,276
0.2	Recruit BCC consultants to be seconded to government (MOHFW, NACO, NRHM, UPSACS)				4 national consultants and 4 UP consultants hired									Candidates need approval by government agency concerned	$587	$229	$76	$206	$76
0.3	Recruit 1 consultant for each of 10 districts				10 district BCC consultants hired									Candidates need approval by district counterparts	$783	$305	$102	$274	$102
0.4	Complete renovation of Delhi office and procure office equipment, furniture, supplies, maintenance, security, and rent				Delhi office ready for occupancy by staff										$748,946	$292,089	$97,363	$262,131	$97,363
0.5	Sign lease and complete renovation of Lucknow office and procure office equipment, furniture, supplies, maintenance, security, and rent				Lucknow office ready for occupancy by staff										$273,003	$106,471	$35,490	$95,552	$35,490
0.6	Set up district offices in 10 districts in UP, sign lease, procure office equipment, furniture, supplies, maintenance, security, and rent				10 district offices operational										$346,502	$135,136	$45,046	$121,274	$45,046
0.7	Home Office operational costs														$24,828	$9,683	$3,228	$8,689	$3,228
0.8	Purchase, register, and maintain 2 vehicles				1 vehicle for Delhi and 1 for Lucknow office operational										$42,418	$16,543	$5,514	$14,847	$5,514
0.9	Conduct orientation meetings for new staff and online training on FP policy guidelines															IHBP staff	IHBP staff	IHBP staff	IHBP staff
0.10	Develop grants manual				Grant RFPs released											IHBP staff	IHBP staff	IHBP staff	IHBP staff

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budget by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/ RH	MCH	HIV/ AIDS	TB
Project Management/Operations																			
0.11	Conduct bi-annual project progress meetings (FHI 360, subcontractors, USAID) to review national, state, and district activities													First meeting in Delhi and second meeting in Lucknow	$17,133	$6,682	$2,227	$5,997	$2,227
0.12	Conduct semi-annual performance meetings with USAID													1 meeting in early March and 1 meeting in early September		IHBP staff	IHBP staff	IHBP staff	IHBP staff
0.13	Finalize Year 2 work plan based on USAID comments and revised AMP for USAID approval													Planned for early October; depends on receipt of USAID comments		IHBP staff	IHBP staff	IHBP staff	IHBP staff
0.14	Develop Year 3 work plan for submission to USAID September 16													Work planning workshop with all IHBP staff and subcontractors	$13,978	$5,451	$1,817	$4,893	$1,817
0.15	Prepare quarterly progress reports, semi-annual reports, and annual reports															IHBP staff	IHBP staff	IHBP staff	IHBP staff
0.16	Award a subcontract to PHFI to provide TA and advocacy with national- and state-level government officials				Government officials approve IHBP actions quickly										$100,445	$39,174	$13,058	$35,155	$13,058
														Subtotal 0.1 – 0.16	*$1,609,210*	*$627,592*	*$209,197*	*$563,224*	*$209,197*
0.17	Fixed Fee														$88,507	$34,518	$11,506	$30,977	$11,506
					Total Project Management									**TOTAL**	**$1,697,717**	**$662,110**	**$220,703**	**$594,201**	**$220,703**

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
Outcome 1: Organizational structure, management systems and processes, and HR for SBCC strengthened at national, state, and district levels																			
1.1	Conduct organizational need assessment of IEC/BCC Units/ divisions/cells				ONA done; findings and recommendation shared with key stakeholders	1.1.1					IEC,RCH, CTD, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS, NIPCCD	Subject to consent from respective ministries/ departments	$212,886	$83,026	$27,675	$74,510	$27,675
1.2	Conduct review of existing M&E system for BCC and disseminate findings and develop/update BCC indicators and tracking system for BCC activities				Assessment done for BCC M&E and findings shared with key stakeholders; tracking system for BCC indicators developed/ updated	1.1.1					IEC, SPMU, DHS	NACO, UPSACS, DAPCU		Subject to consent from respective ministries/ departments	$96,645	$37,692	$12,564	$33,825	$12,564
1.3	Conduct rapid assessment of supervisory system and quality of supervision to frontline workers for IPC				CB needs assessment for supervisors to ASHAs, ANMs, AWWs, and link workers done	1.1.1, 2.4.1					SPMU, DTC, DHS	UPSACS, DAPCU			$36,811	$14,357	$4,785	$12,884	$4,785
1.4	BCC capacity needs assessment for frontline workers • HFW - AWWs, ASHAs, ANMs • RNTCP - DOTS providers, DMC • SACS - Link workers, ICTC counselors, etc.				Input from CB needs assessment incorporated in SBCC course content and for developing IPC job aids	1.2.1, 1.2.3					NIHFW, SIHFW	UPSACS	NIPCCD (regional)	TNA to include: • Desk review of teaching and learning materials • Review of IPC job aids • Field assessment with workers	$100,840	$39,328	$13,109	$35,294	$13,109
1.5	Meetings/workshops with relevant departments to develop capacity strengthening plans and advocate for their implementation				Capacity strengthening plans prepared, approved for implementation	1.1.1					IEC,RCH, CTD, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS, NIPCCD	This may lead to developing BCC cells in the districts		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.6	Advocate for strengthening institutional capacity for BCC through improved job descriptions, task shifting, strengthening hardware and software for planning, implementing and monitoring, etc.				Agreement from government to improve institutional capacity	1.1.1, 1.1.2, 1.1.3					IEC, SPMU, SIFPSA	NACO, UPSACS		Will need approval from secretary/joint secretary to modify job descriptions, etc.		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
1.7	Hire BCC consultants based on SOW agreed to between relevant divisions and IHBP, and approved by USAID [Linked to 1.1 and 1.5]				Long- and short-term consultants placed in relevant ministries and state departments	1.1.2, 1.2.1					IEC, SIFPSA, NIHFW, SIHFW, CTD, STC, DHS	NACO, UPSACS, DAPCU	ICDS, NIPCCD		$353,000	$137,670	$45,890	$123,550	$45,890
1.8	Conduct half-day SBCC orientations for health program officials/policy makers [Linked to 1.5]				Capacities of program managers and IEC/BCC staffs strengthened	1.1.2, 1.2.2					MOHFW, DFW, DHS	NACO, UPSAC, DAPCU	MWCD, DWCD, ICDS projects		$20,918	$8,158	$2,719	$7,322	$2,719
1.9	Orient training institutes on the project and develop joint working plans [Linked to 1.5]				Capacities of program managers and IEC/BCC staffs strengthened	1.1.2, 1.2.3, 1.2.2					NIHFW, NHSRC, SIHFW		NIPCCD (national and regional)			IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.10	Advocacy for M&E BCC indicators based on results of M&E review				Developed/ updated M&E BCC indicators included in MIS of government at national and state levels [Linked to output of 1.2]	1.1.1					IEC, NIHFW	UPSACS	NIPCCD		$17,277	$6,738	$2,246	$6,047	$2,246
1.11	Assist government in media planning and media monitoring for campaigns in the four program elements [Linked to 1.1, 1.2, and 1.5]				IEC Units of key ministries and divisions assisted in planning campaigns and monitoring them	2.1.2					IEC, RNTCP, RCH, SPMU	NACO, UPSACS		We may need to hire 1 media agency at the national level and 1 at the state level	$104,125	$40,609	$13,536	$36,444	$13,536
1.12	Develop tools for district and block officials and selected civil society organizations to monitor implementation of IEC/BCC activities and provide feedback [Linked to 1.1, 1.2, 1.3, and 1.5]				BCC monitoring and feedback tools for district and block officials	1.1.3, 2.4.1, 3.1.2					DHS			Subject to findings of review of existing M&E for BCC [1.2]		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.13	Assist district and block officials and selected civil society organizations to compile and analyze information on IEC/BCC activities in the district [Linked to 1.12]				BCC monitoring results shared with DHS	2.4.1, 3.1.2					DHS					IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
1.14	Support quarterly BCC coordination meetings in each district, under chairpersonship of the district magistrate [Linked to 1.12 and 1.13]				DHS regularly reviews and plans mid-media and IPC activities	2.1.2, 3.1.2					DHS					IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.15	Advocate with state and district officials to include BCC training in training calendars for frontline health workers [Linked to 1.4 and 1.5]				NRHM and NACP PIP/training calendars for the state and districts include BCC training	1.1.3, 1.2.3					SPMU, SIFPSA, DHS, STC	UPSACS				IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.16	Facilitate exposure visits of key IEC staffs to intra-country sites of promising practices in SBCC [Linked to 1.5]				Capacities of program managers and IEC/BCC staffs strengthened	1.2.3					IEC, SIFPSA, STC, SPMU, DFW	NACO, UPSACS		Will identify promising practices sites and coordinate visit	$42,756	$16,675	$5,558	$14,965	$5,558
1.17	Establish and facilitate meetings of BCC partners forum at national and state levels				Stakeholders forum on BCC established	2.1.2					IEC, SPMU	NACO, UPSACS	MWCD, DWCD	USAID, its partners, and other donors will be included	$19,889	$7,757	$2,586	$6,960	$2,586
1.18	Based on the SOW agreed between USAID and IHBP, facilitate meetings of PAGs at national and state levels				PAGs established and functional	1.3.1, 1.3.2					IEC, SPMU	NACO, UPSACS	MWCD, DWCD	Will need consent from MOHFW at national and state levels to chair the PAGs	$15,836	$6,176	$2,059	$5,542	$2,059
Outcome 2: SBCC training developed and conducted for improved competencies in evidence-based SBCC at national, state, and district levels																			
1.19	Assist NIHFW and SIHFW in developing innovative training strategy and curriculum and master trainers, and promoting NIHFW at center of excellence for BCC trainings				Master trainers trained to implement an innovative strategy for frontline workers	1.2.1, 1.2.3					NIHFW, SIHFW			IHBP foresees significant challenges in rollout; huge numbers of frontline workers, lack of sufficiently skilled trainers at district levels, etc.; will need innovative training approaches; IHBP will hire a consultant to develop training curriculum	$32,907	$19,745	$6,581		$6,581
1.20	Assist relevant training institutes in developing SBCC course/ content and in integrating it into its annual training calendar (IPC and community mobilization for frontline workers) [Advocacy for this is in 1.5, 1.6, and 1.9]				A regular course in SBCC in NIHFW and SIHFW	1.2.1, 1.2.3					NIHFW, SIHFW			Content will be customized to the training approach	$46,960	$28,176	$9,392		$9,392

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
1.21	Develop training tools (modules, training aids, and job aids) in SBCC planning, implementation, and M&E for program managers and frontline workers				Training tools and job aids available	1.2.1, 1.2.3					IEC	NACO			$43,894	$17,119	$5,706	$15,363	$5,706
1.22	Develop, in consultation with relevant stakeholders, training strategy and plans for strengthening BCC in VHNDs and VHSCs [Refer to 3.1]				Training strategies and plans prepared and integrated in state and district PIPs	3.1.1					SPMU, DHS				$10,418	$7,814	$2,604		
1.23	Train a pool of master trainers in NIHFW and SIHFW on SBCC module/course [Advocacy for including it in PIP is in 2.2]				National and state pool of master trainers in SBCC	1.2.1, 1.2.3					NIHFW, SIHFW				$56,505	$33,903	$11,301		$11,301
1.24	Assist NIHFW and SIHFW create pools of district-level Trainers in SBCC [Advocacy for including it in PIP is in 2.2]				District pool of trainers for SBCC in project districts	1.2.1, 1.2.3					NIHFW, SIHFW, DHS				$39,442	$23,666	$7,888		$7,888
1.25	Conduct SBCC workshops for IEC staff at national and state levels				Capacities of program managers and IEC/BCC staffs strengthened	1.1.2, 1.2.2, 1.2.3					IEC, RCH, CTD, SIFPSA, STC, RCH	NACO, UPSACS		This may be an recommendation of ONA	$23,791	$9,278	$3,093	$8,327	$3,093
1.26	Support SIFPSA in SBCC workshops for IEC staff at districts				SPMU-NRHM and SIFPSA assisted in training master trainers in BCC and in rolling out BCC training in the 10 IHBP districts Capacities of program managers and IEC/BCC staffs strengthened	1.1.2, 1.2.2, 1.2.3					DHS, DHEIO, BHEIO, DMCs	DAPCU			$17,749	$10,649	$3,550		$2,550
Outcome 3: SBCC nodal institutions identified and strengthened at national level and in UP																			
1.27	Scoping study to identify nodal organizations				Nodal organizations selected, approved by USAID and government, and subcontracted	1.3.1, 1.3.2					IEC, SPMU	NACO, UPSACS			$56,445	$22,014	$7,338	$19,755	$7,338

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
1.28	Conduct ONA with selected/ subcontracted nodal organizations				ONA done	1.3.1, 1.3.2									$48,130	$18,771	$6,257	$16,845	$6,257
1.29	Based on findings from ONA, develop, in consultation with nodal organizations, their capacity building plans and training calendars				Capacity strengthening plans for nodal organizations	1.3.1, 1.3.2										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.30	Train nodal organizations in SBCC approach, community mobilization, and other key areas identified through CB needs assessment				Staffs of nodal organizations trained in SBCC	1.3.1, 1.3.2									$48,513	$18,920	$6,307	$16,979	$6,307
1.31	Involve nodal organizations in TA for IRs 2, 3, and 4					1.3.1, 1.3.2								Subcontract to Nodal Organizations	$383,835	$149,696	$49,898	$134,343	$49,898
					Activities & Deliverables for IR 1									**Subtotal 1.1 – 1.31**	*$1,829,572*	*$757,937*	*$252,642*	*$568,955*	*$250,038*
1.32	Local Staff Salaries & Fringe Benefits (IR 1)														$1,070,897	$417,650	$139,217	$374,813	$139,217
1.33	Home Office Salaries & Fringe Benefits (IR 1)														$347,539	$135,540	$45,180	$121,639	$45,180
					Salaries & Fringe Benefits for IR 1								**Subtotal**	*$1,418,436*	*$553,190*	*$184,397*	*$496,452*	*$184,397*
1.34	Local Consultants (IR 1)														$51,540	$20,101	$6,700	$18,039	$6,700
1.35	International Consultants (IR 1)														$94,607	$36,898	$12,299	$33,111	$12,299
					Consultants for IR 1									**Subtotal**	*$146,147*	*$56,999*	*$18,999*	*$51,150*	*$18,999*

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 1: Capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels																			
1.36	Local Travel (Field & HQ) (IR 1)														$182,046	$70,998	$23,666	$63,716	$23,666
1.37	International Travel (HQ & International Consultants) (IR 1)														$121,413	$47,351	$15,784	$42,494	$15,784
					Travel Costs for IR 1									**Subtotal**	*$303,459*	*$118,349*	*$39,450*	*$106,210*	*$39,450*
1.38	Subcontracts with Pop Council and PCI (IR 1)														$56,456	$22,018	$7,339	$19,760	$7,339
1.39	Fixed Fee														$206,474	$82,967	$27,655	$68,339	$27,512
					TOTAL COSTS FOR IR 1									**TOTAL**	**$3,960,544**	**$1,591,460**	**$530,482**	**$1,310,866**	**$527,735**

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 2: Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers, district, state, and national levels																			
Outcome 1: Evidence-based strategic SBCC plans integrated as part of program plans for HIV/AIDS, FP/RH, TB, and MCH																			
2.1	Participate in working groups and development partners' consultation on NACP-IV, NRHM-II, and ICDS-IV at national and state levels; advocate for and assist them in drafting long-term strategies for BCC, advocacy, and social mobilization				Evidence-based BCC strategies and approaches included in NRHM--II, NACP-IV, and ICDS-IV	2.1.2					IEC, CTD, SPMU, STC	NACO, UPSACS	MOWCD			IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.2	Participate in consultations on annual PIPs; assist in drafting sections related to BCC, like materials development, capacity building; and advocate for resource allocation (HR, financial, and technical) for BCC				Short-term (1-year) BCC strategy and plans developed, approved, and funded	1.1.1, 2.1.1, 1.1.3					IEC, CTD, SPMU, STC	NACO, UPSACS				IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.3	Support development of campaign strategies around key thematic areas (like safe motherhood, birth preparedness, FP, breastfeeding, HIV/AIDS prevention, ICTC, etc.) [Linked to 1.5, 1.6, 1.11, 2.2, and 2.3]				IEC Units of key ministries and divisions assisted in planning campaigns and monitoring them	2.1.2, 2.1.3					IEC, CTD, RCH, SPMU, SIFPSA, STC	NACO, UPSACS				IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.4	Advocate with district officials to develop, strengthen, and/or operationalize (as indicated) IEC/BCC events calendar for the district [Linked to 1.5,1.12, 1.13, and 1.14]				More IPC and mid-media activities conducted	1.1.3					DHS					IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.5	Collect evidence through qualitative studies and operations research for improved planning and implementation of BCC activities				New evidence for BCC strategy and action plans in the state; media mapping reviewed	2.1.3					MOHFW	NACO, UPSACS		IHBP has identified eight areas in FP/MCH and six research areas in HIV/AIDS; need more information for TB	$455,585	$204,193	$68,110	$183,282	
2.6	Assist UPSACS in conducting communications needs assessment in the state				Assessment completed and report disseminated	2.1.1						UPSACS			$15,035			$15,035	
2.7	Assist UPSACS in developing a BCC strategy for HIV/AIDS in the state [Linked to 1.5 and 1.6]				Short- and long-term BCC strategy and plans developed	2.1.3						UPSACS			$18,774			$18,774	

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 2: Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers, district, state, and national levels																			
2.8	Assist FP division of the MOHFW in developing repositioning strategy for FP in 11 states				Repositioning strategy for FP developed for 11 states	2.1.3, 2.2.1, 2.2.2					MOHFW					IHBP staff			
2.9	Implement repositioning strategy for FP at national and state levels				Implementation plan developed for FP repositioning	2.1.3, 2.1.4					MOHFW			Hire agency to create prototype of revised content	$15,376	$15,376			
Outcome 2: IPC, mid-media, and mass media strategies and materials on HIV/AIDS, FP/RH, TB, and MCH updated and improved																			
2.10	Review IPC, mid-media, and mass media strategies and materials in use for frontline workers [Linked to 1.4]				Areas for further strengthening and need for new materials identified; IEC materials reviewed	2.2.1, 2.2.2					IEC, RCH, CTD, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS	Need to hire consultants for this assignment	$88,601	$34,554	$11,518	$31,011	$11,518
2.11	Assist relevant divisions improve their existing IPC, mid-media, and mass media strategies and prototypes [Linked to 2.2, 2.3, 2.4, and 2.5]				IPC, mid-media, and mass media strategies modified and improved; new IPC, mid-media, and mass media materials developed	2.2.1, 2.2.2					IEC, CTD,RCH, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS	Need to hire an agency for this assignment	$206,673	$80,602	$26,868	$72,335	$26,868
2.12	Support, as per emerging needs, development of new IEC/BCC products [Linked to 2.2, 2.3, and 2.11]				Planning and implementation of BCC activities improved and streamlined; materials produced	2.2.1, 2.2.2					IEC, CTD, RCH, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS	Need to hire an agency for this assignment	$403,879	$157,513	$52,504	$141,358	$52,504
Outcome 3: IPC and mid-media activities/campaigns implemented by government and private sector partner organizations																			
2.13	Quantitative study to establish KAP among general population and frontline workers				Baseline KAP survey reports for project districts	2.3.3, 2.3.4, 2.3.5					IEC, CTD, RCH, SPMU, SIFPSA, STC	NACO, UPSACS	ICDS	Need to hire a research agency for this assignment	$546,540	$213,151	$71,050	$191,289	$71,050

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 2: Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers, district, state, and national levels																			
2.14	Activities of mid-media, IPC supported by Grants program and TA provided to government in implementing mid-media and IPC strategies				IPC and mid-media activities/ campaigns implemented	2.3.1, 2.3.2, 2.3.3, 2.3.4, 2.3.5, 2.3.6					IEC, CTD, SPMU, STC	NACO, UPSACS	ICDS		$235,418	$91,813	$30,604	$82,397	$30,604
Outcome 4: IPC activities regularly monitored and feedback provided to ASHAs, ANMs, and AWWs																			
2.15	Provide technical support to ASHAs, ANMs, and AWWs for monitoring				Output linked to 1.3, 1.12, 1.13, 1.14, 1.22, and 3.19	2.4.1					MOHFW, SPMU		ICDS			IHBP staff and con-sultants	IHBP staff and con-sultants	IHBP staff and con-sultants	IHBP staff and con-sultants
2.16	Mentoring, on-the-job support to district and block supervisors in using tools for M&E and supervision				On-the-job support to BHEIOs in monitoring and supervising BCC activities provided	2.4.1					SPMU, DHS	UPSACS							
2.17	Assist district trainers in training supervisors to ASHAs, ANMs, and AWWs in supportive supervision				Supportive supervision training initiated for supervisors of frontline workers	2.4.1					DHS		ICDS project	The number of blocks to receive intensive support TBD	$23,665	$14,199	$4,733		$4,733
					Activities & Deliverables for IR 2									**Subtotal 2.1 – 2.17**	*$2,009,546*	*$811,401*	*$265,387*	*$735,481*	*$197,277*
2.18	Local Staff Salaries & Fringe Benefits (IR 2)														$475,997	$185,639	$61,880	$166,598	$61,880
2.19	Home Office Salaries & Fringe Benefits (IR 2)														$154,462	$60,240	$20,080	$54,062	$20,080
					Salaries & Fringe Benefits for IR 2								**Subtotal**	*$630,459*	*$245,879*	*$81,960*	*$220,660*	*$81,960*
2.20	Local Consultants (IR 2)														$45,038	$17,565	$5,855	$15,763	$5,855
2.21	International Consultants (IR 2)														$30,971	$12,079	$4,026	$10,840	$4,026

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 2: Accurate and appropriate knowledge, attitudes increased among individuals, families, communities, and providers, district, state, and national levels																			
					Consultants for IR 2									**Subtotal**	*$76,009*	*$29,644*	*$9,881*	*$26,603*	*$9,881*
1.36	Local Travel (Field & HQ) (IR 2)														$99,689	$38,879	$12,960	$34,890	$12,960
1.37	International Travel (HQ & International Consultants) (IR 2)														$53,961	$21,045	$7,015	$18,886	$7,015
					Travel Costs for IR 2									**Subtotal**	*$153,650*	*$59,924*	*$19,975*	*$53,776*	*$19,975*
1.38	Subcontracts with Pop Council, PSI and PCI (IR 2)														$445,806	$173,864	$57,955	$156,032	$57,955
1.39	Fixed Fee														$182,351	$72,639	$23,934	$65,590	$20,188
					TOTAL COSTS FOR IR 2									**TOTAL**	$3,497,821	$1,393,351	$459,092	$1,258,142	$387,236

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors																			
Outcome 1: Organization and coordination of communication platforms for IPC and/or mid-media at village level strengthened																			
3.1	Desk review of existing guidelines for VHNDs and VHSCs				Desk review of guidelines done	3.1.1					SPMU, DHS			PSI will do the desk review	$34,945	$26,209	$8,736		
3.2	Field visits to review existing guidelines and VHSCs				Field assessment done	3.1.1								FHI 360 to hire agency for field assessment	$13,978	$10,483	$3,495		
3.3	Revised guidelines developed				Revised guidelines developed for VHNDs and VHSCs	3.1.1										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.4	Discussion with district-level officials on reviewed/revised guidelines for VHSCs and VHNDs for implementation in the districts				Revised guidelines for VHSCs/VHNDs initiated in the districts	3.1.1, 3.1.2					DHS			Printing of revised guidelines	$2,796	$2,097	$699		
Outcome 2: Community groups mobilized and trained to organize or facilitate IPC and mid-media activities at the community level																			
3.5	Review evidence of promising practices and develop community mobilization strategies for health issues				Community mobilization strategies finalized	3.2.1, 3.3.2					SPMU, DHS	UPSACS, DAPCU	ICDS		$6,894	$2,689	$896	$2,413	$896
3.6	Implement community mobilization strategies based on Grants program				Local civil society organizations provided grants to implement community mobilization strategies	3.1.2, 3.2.1, 3.2.2, 3.3.2					DHS	UPSACS			$251,112	$97,934	$32,645	$87,888	$32,645
3.7	Training of civil society organizations in community mobilization strategies				Selected civil society organizations are oriented on community mobilization strategies and project produced campaigns/ materials	3.2.2, 3.2.3, 3.3.2, 3.3.3									$31,264	$12,193	$4,064	$10,943	$4,064
3.8	Support community mobilization activities funded by government at district level				Community mobilization activities funded by government initiated in districts	2.4.1, 3.1.1, 3.1.2										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors																			
3.9	Monitoring and reporting templates for regular reporting by civil society organizations created and shared [Linked to 2.15]				Monitoring and reporting plans in place and reports received	2.4.1, 3.2.1, 3.2.2										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
Outcome 3: Advocacy and community mobilization plans, materials, messages, and training modules developed and pretested																			
3.10	Review existing advocacy materials used for advocating with community leaders to support health behaviors				Report on gaps in health-related advocacy materials	3.1.1								Hire an agency	$42,390	$16,532	$5,511	$14,836	$5,511
3.11	Stakeholders consultations to develop advocacy strategy on specific thematic areas (HIV/AIDS, TB, MCH, and FP/RH)				Advocacy issues identified and strategies developed	3.3.1, 3.4.1, 3.5.1									$8,060	$3,143	$1,048	$2,821	$1,048
3.12	Develop new advocacy materials and hold workshop with alliances on selected issues				New materials (print and AV) developed Alliances and networks undertake issue-based advocacy with IHBP support	3.3.1, 3.4.1, 3.4.2, 3.5.1									$105,703	$41,224	$13,741	$36,997	$13,741
3.13	Identify people (and/or institutions) who have potential to be champions or spokespersons for issues identified by IHBP for advocacy				Capacity building plans for champions and spokespersons	3.3.3										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.14	Capacity needs assessment for selected champions and spokespersons [same activity in IR 4]				Capacity building plans for champions and spokespersons	3.3.3								To be done internally by the Advocacy Specialist/ SM Specialist		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.15	Develop capacity building plans and materials based on findings of capacity needs assessment for champions and spokespersons				Capacity building plans for champions and spokespersons	3.3.3								To be done internally		Cost included in Activity 3.22	Cost included in Activity 3.22	Cost included in Activity 3.22	Cost included in Activity 3.22
3.16	Training in advocacy for selected champions and spokespersons [same in IR 4]				Identified champions and spokespersons trained in advocacy and related health topics	3.3.3								Including 1 exposure visit	$40,627	$15,845	$5,281	$14,220	$5,281

		Level				Activity timeline				Ministries/ Dept. (mention specific agency/division)				Budgets by Component			
Key Activities		National	State	District	Expected Output (Milestone)	AMP indicators	Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD	Remarks	Total Budget (in USD)	FP/RH	MCH	HIV/AIDS	TB
IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors																			
Outcome 4: Existing alliances strengthened and new alliances formed, if necessary																			
3.17	Mapping and scoping of alliances and networks working in four thematic areas				Alliances and networks at national, state, and district levels mapped	3.4.1									$47,915	$18,687	$6,229	$16,770	$6,229
3.18	Capacity needs assessment for selected alliances and networks, including SWOT, synergies that various networks and alliances can develop and their ability to leverage				Capacity building needs assessments done for alliances and networks	3.4.1										Included in budget for Activity 3.27	Included in budget for Activity 3.27	Included in budget for Activity 3.27	Included in budget for Activity 3.27
3.19	Develop action plans for strengthening capacities of alliances and networks and expanding their linkages				Capacity strengthening plans developed for selected alliances and networks	3.4.1										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.20	Commencement of training in advocacy and SBCC for selected alliances and networks [Linked to 3.22 and 3.35]				Issue specific advocacy and SBCC trainings initiated for selected alliances and networks	3.4.1										Included in budget for Activity 3.26	Included in budget for Activity 3.26	Included in budget for Activity 3.26	Included in budget for Activity 3.26
Outcome 5: Media engaged as supportive partner at national and UP levels																			
3.21	Based on RFP, complete media mapping initiated in Year 1				Media mapping done	3.5.1									$19,569	$7,632	$2,544	$6,849	$2,544
3.22	Develop media advocacy plans, based on media mapping exercise and advocacy issues selected				Media advocacy plan	3.5.1										IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors																			
3.23	Develop IHBP documentation plan (KM); train IHBP staffs and partners, subcontracted civil society organizations, and selected alliances and networks in documenting success stories, articles, and scripts (KM)				Documentation plan for IHBP developed; project staff, partners, subcontracted civil society organizations, and other relevant stakeholders trained in documenting successful and promising stories	3.5.1									$10,992	$4,287	$1,429	$3,847	$1,429
3.24	Subcontract/hire a PR agency, based on RFP for media monitoring, editing stories, articles and scripts provided by the project and facilitating their placement with selected media partners				PR agency hired for media monitoring, editing project stories, and facilitating their placement	2.3.3, 3.3.3, 3.5.1								Including Activity 3.33 and developing training material in its SOW	$47,330	$18,459	$6,153	$16,565	$6,153
Outcome 6: Positive behaviors by health workers and community members recognized and reinforced																			
3.25	Review (desk review and field reviews) community-based rewards and recognition scheme for frontline workers				Report of promising practices in community recognition scheme	3.6.1					SPMU, DHS	NACO, UPSACS		PSI is leading this activity; IHBP will undertake field reviews; PSI is doing it using internal project-funded resources and IHBP will do it using SM Specialist; funding specified with staff		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.26	Assist the project districts in developing guidelines for community-based reward and recognition of frontline functionaries and community members (with focus on the BCC roles) developed				District-level innovations in community-based recognition of frontline workers	3.6.1					SPMU, DHS					IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
3.27	Mentor DHEIOs and BHEIOs in assisting VHSCs in community recognition scheme (CRS) implementation (district /block level/village) [Linked to 1.3, 1.22, and 3.1]				Community platforms, like VHSCs, adopt CRS	3.6.1, 3.6.2					DHS					IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 3: Community platforms, organizations, and key individuals (influencers) support improved healthy behaviors																			
					Activities & Deliverables for IR 3									**Subtotal 3.1 – 3.27**	*$663,575*	*$277,414*	*$92,471*	*$214,149*	*$79,541*
3.28	Local Staff Salaries & Fringe Benefits (IR 3)														$594,943	$232,027	$77,343	$208,230	$77,343
3.29	Home Office Salaries & Fringe Benefits (IR 3)														$193,077	$75,300	$25,100	$67,577	$25,100
					Salaries & Fringe Benefits for IR 3									**Subtotal**	*$788,020*	*$307,327*	*$102,443*	*$275,807*	*$102,443*
3.30	Local Consultants (IR 3)														$18,820	$7,340	$2,447	$6,587	$2,447
3.31	International Consultants (IR 3)														$41,584	$16,218	$5,406	$14,554	$5,406
					Consultants for IR 3									**Subtotal**	*$60,404*	*$23,558*	*$7,853*	*$21,141*	*$7,853*
3.32	Local Travel (Field & HQ) (IR 3)														$72,568	$28,301	$9,434	$25,399	$9,434
3.33	International Travel (HQ & International Consultants) (IR 3)														$67,451	$26,306	$8,769	$23,607	$8,769
					Travel Costs for IR 3									**Subtotal**	*$140,019*	*$54,607*	*$18,203*	*$49,006*	*$18,203*
3.34	Subcontracts with Pop Council, PSI and PCI (IR 3)														$510,450	$199,075	$66,359	$178,657	$66,359
3.35	Fixed Fee														$118,936	$47,409	$15,803	$40,632	$15,092
					TOTAL COSTS FOR IR 3									**TOTAL**	**$2,281,405**	**$909,390**	**$303,132**	**$779,392**	**$289,491**

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 4: Vulnerable communities empowered to seek health services and products																			
Outcome 1: Evidence reviewed and strategies and materials prepared																			
4.1	Desk review of successful strategies in reducing stigma and discrimination reduction in India and South Asia [Linked to 3.5]				Promising practices report, along with compilation of tools used for empowering vulnerable communities	4.1.1, 4.1.2					CTD	NACO			$21,926			$15,988	$5,938
4.2	Undertake qualitative studies on vulnerable groups (PLHIV/women [pregnant/wives of migrants/HIV-positive], TB patients) [Linked to 2.6, 2.5, 2.13, and 3.23]					4.1.1					STC	UPSACS		Finding will contribute to identifying advocacy issues and strategies	$139,780			$101,928	$37,852
4.3	Stakeholder workshops to develop stigma and discrimination reduction strategies for PLHIV and people living with TB				Key approaches to stigma and discrimination reduction strategies defined	4.1.1					CTD, STC	NACO, UPSACS			$26,954			$19,654	$7,300
Outcome 2: Knowledge and ability of health providers and frontline workers on gender, stigma on HIV/AIDS, TB, and other forms of discrimination improved																			
4.4	Advocate for including orientations and sensitization on gender inequity, stigma, and discrimination in district-level activities, including trainings, promotional events, etc.				Stigma and discrimination-related orientation and sensitization plans developed for frontline health workers	1.2.2, 4.2.1					SPMU, SIFPSA, DHS, STC	UPSACS				IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
4.5	Revise/create content for sensitizing frontline workers working with health department and SACS in the state on stigma and discrimination issues				On-the-job training modules for health workers developed	4.2.1, 4.2.2, 4.2.3					SPMU, SIFPSA, DHS, STC	UPSACS		Need to hire a training materials consultant	$26,203		$5,584	$15,035	$5,584
4.6	Train IHBP district team and grant supported civil society organizations for sensitizing health workers on stigma and discrimination				Health workers orientation and sensitization initiated in project districts	4.2.1, 4.2.3					DHS	DAPCU			$16,585		$3,534	$9,517	$3,534

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 4: Vulnerable communities empowered to seek health services and products																			
Outcome 3: KAP of men are improved																			
4.7	Based on findings of studies conducted under 2.5 and 2.13, undertake state-level consultations for developing approach paper involving men in reducing stigma and discrimination against women living with HIV and TB and presenting this in a 1-day workshop				Approach paper for involving men in reducing stigma and discrimination	4.3.1					SPMU, CTD	UPSACS			$12,735			$9,286	$3,449
Outcome 4: Programs to reach vulnerable groups, improve their self- efficacy, and empower them using a rights-based approach																			
4.8	Specific activities to reach vulnerable groups planned and initiated through grants and mobilizing government funds				Outputs as shared for 3.20 to 3.26 and 3.32 to 3.34	4.4.1								Grants	$52,315	$20,403	$6,801	$18,310	$6,801
					Activities & Deliverables for IR 4									**Subtotal 4.1 – 4.8**	*$296,498*	*$20,403*	*$15,919*	*$189,718*	*$70,458*
4.9	Local Staff Salaries & Fringe Benefits (IR 4)														$237,976	$92,811	$30,937	$83,291	$30,937
4.10	Home Office Salaries & Fringe Benefits (IR 4)														$77,231	$30,120	$10,040	$27,031	$10,040
					Salaries & Fringe Benefits for IR 4									**Subtotal**	*$315,207*	*$122,931*	*$40,977*	*$110,322*	*$40,977*
4.11	Local Consultants (IR 4)														$10,253	$3,998	$1,333	$3,589	$1,333
4.12	International Consultants (IR 4)														$12,074	$4,709	$1,570	$4,225	$1,570
					Consultants for IR 4									**Subtotal**	*$22,327*	*$8,707*	*$2,903*	*$7,814*	*$2,903*
4.13	Local Travel (Field & HQ) (IR 4)														$33,877	$13,212	$4,404	$11,857	$4,404
4.14	International Travel (HQ & International Consultants) (IR 4)														$26,981	$10,523	$3,508	$9,442	$3,508

Key Activities		Level			Expected Output (Milestone)	AMP Indicators	Activity Timeline				Ministries/Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
IR 4: Vulnerable communities empowered to seek health services and products																			
					Travel Costs for IR 4									**Subtotal**	*$60,858*	*$23,735*	*$7,912*	*$21,299*	*$7,912*
3.34	Subcontracts with Pop Council (IR 4)														$69,815	$27,228	$9,076	$24,435	$9,076
3.35	Fixed Fee														$42,059	$11,165	$4,223	$19,447	$7,223
					TOTAL COSTS FOR IR 4									**TOTAL**	**$806,764**	**$214,169**	**$81,010**	**$373,035**	**$138,549**

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
Cross-Cutting: Knowledge Management																			
Outcome 1: Systems established to disseminate and share information with key audience																			
1.1	Launch and operationalize project website				Project website launched and updated regularly Process operationalized for sourcing information to update project website										$21,526	$8,395	$2,798	$7,535	$2,798
1.2	Train IHBP staff and subcontractors on using and updating IHBP Intranet (a sub-component of project website)				IHBP staff and subcontractors trained on using and updating relevant sections of IHBP Intranet											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.3	Produce and disseminate IHBP newsletter				Newsletter generated and shared with stakeholders on a quarterly basis											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.4	Conduct review and recommend new and innovative media for knowledge sharing and dissemination				Innovative tools, e.g., blogs, mobile communication etc., evaluated and recommended											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
1.5	Synthesize and disseminate recent innovations in BCC				A "BCC Resource Bulletin" generated and disseminated to stakeholders on a periodic basis											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
Outcome 2: KM and knowledge-sharing skills of key stakeholders strengthened to create knowledge and use information																			
2.1	Map and review current information vehicles (information dissemination systems) of ministries and government bodies				Mapping study (desk review) completed; opportunities for partnership/ support identified with regard to existing information vehicles/systems New and innovative media recommended for wider information dissemination						MOHFW, NIHFW	NACO, UPSACS	MOWCD			IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.2	Support ministries and government bodies in setting/strengthening IEC/BCC Resource Centers (virtual and/or physical)				Ministry/ government bodies helped in design and/or development of information dissemination systems						MOHFW, NIHFW		MOWCD		$61,503	$36,901	$12,301		$12,301
2.3	Provide TA dissemination of government communication outputs developed under IRs 1, 2, 3, and 4 with support from IHBP				Ministry/ government bodies helped in design and/or development of information dissemination systems						MOHFW, DFW	NACO, UPSACS	MWCD, DWCD	The outputs may include research results, BCC strategy, etc., among others; the channels may include project website, knowledge sharing sessions, blogs		IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.4	Identify and operationalize good KM practices				Good practices shared and integrated in project activities (across IRs)											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
					Activities & Deliverables for Knowledge Management									**Subtotal 1.1 – 2.4**	*$83,029*	*$45,296*	*$15,099*	*$7,535*	*$15,099*

Key Activities		Level: National	Level: State	Level: District	Expected Output (Milestone)	AMP indicators	Activity timeline: Q1	Q2	Q3	Q4	Ministries/ Dept. (mention specific agency/division): MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD	Remarks	Total Budget (in USD)	Budgets by Component: FP/RH	MCH	HIV/AIDS	TB
	Fixed Fee														$4,567	$2,491	$830	$414	$830
					Total Knowledge Management									**TOTAL**	**$87,596**	**$47,787**	**$15,929**	**$7,949**	**$15,929**
Cross-Cutting: Leveraging																			
Outcome 1: Full-time IHBP leveraging staff hired and local consultants as needed by FHI 360 and PSI																			
1.1	Interview short-listed candidates				USAID staff approval submitted														
Outcome 2: Strategy developed and validated through consultation with potentially interested partners																			
2.1	HQ consultant travels to India to conduct consultative meetings with potential partners																		
2.2	Exploratory discussions held with private sector commercial companies and various organizations, such as FICCI, to determine mutual interests				Meeting minutes that will feed into strategy development and a short list of potential partners											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
2.3	Continue meetings, develop relationships and MOUs to clarify roles, responsibilities, and contributions				MOU with organizations										$910,281	$355,010	$118,337	$318,597	$118,337
Outcome 3: Implement leveraging strategy that targets health-related support at the national or UP level and includes private, commercial, and nonprofit sectors and government contributions																			
3.1	Document contributions of cash and in kind activities conducted by leveraging partners				Quarterly documentation of activities conducted and dollar value attributed submitted with USAID quarterly reports											IHBP Staff	IHBP Staff	IHBP Staff	IHBP Staff
					Activities & Deliverables for Leveraging									**Subtotal 1.1 – 3.1**	*$910,281*	*$355,010*	*$118,337*	*$318,597*	*$118,337*
	Fixed Fee														$50,065	$19,526	$6,509	$17,523	$6,509

Key Activities		Level			Expected Output (Milestone)	AMP indicators	Activity timeline				Ministries/ Dept. (mention specific agency/division)			Remarks	Total Budget (in USD)	Budgets by Component			
		National	State	District			Q1	Q2	Q3	Q4	MOHFW/ DFW	NACO/ UPSACS	MWCD/ DWCD			FP/RH	MCH	HIV/AIDS	TB
					Total Leveraging									**TOTAL**	$960,346	$374,536	$124,846	$336,120	$124,846
					TOTAL BUDGET									**TOTAL COST**	**$13,292,192**	**$5,192,803**	**$1,735,194**	**$4,659,706**	**$1,704,489**